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Supreme Court, U.S.
FILED

No. 97 2079 JUN 1 1998

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

CALIFORNIA AMBULANCE ASS'N and
CALIFORNIA MEDICAL ASS'N ET AL.
Petitioners

v.

S. KIMBERLY BELSHE, Director of the California
Department of Health Services,
and
DONNA E. SHALALA, Secretary of the United States
Department of Health and Human Services,
Respondents

On Petition for Writ of Certiorari To The United States Court of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, prior to the enactment of the Balanced Budget Act of 1997, the Medicaid Act (42 U.S.C. sections 1396a(a)(10)(E), 1396a(n), and 1396d(p)) permitted states to limit or eliminate their Medicare "cost-sharing" payments for "Qualified Medicare Beneficiaries"?

2. What deference, if any, should the courts give to the views of a subsequent Congress that purports to clarify or interpret the intent of a statute enacted by an earlier Congress, and, if deference is to be given, what standards or principles, as well as judicial obligations, should guide the courts in determining the extent of such deference?

3. Whether Congress, consistent with Article III of the Constitution, may apply a new law to direct the outcome of litigation to which the United States is a party in order to benefit the federal government without changing the law retroactively as to non-litigants?

4. Whether a retroactive change in the law, resulting in a reduction of the statutory rate of payment to health care providers for services already provided to certain federal beneficiaries impairs vested property rights protected by the Takings Clause of the Fifth Amendment to, and by Article I, §10 of, the U.S. Constitution.

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The California Ambulance Association, the California Medical Association, and other physician associations (collectively "Associations" or "Petitioners")[1] respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case in favor of respondents, Donna E. Shalala, as Secretary of the United States Department of Health and Human Services ("Secretary") and S. Kimberly Belshe, as Director of the California Department of Health Services ("State Director").

OPINIONS BELOW

The opinion of the Court of Appeals (App., 1-23) is reported at 132 F.3d 1259. The opinions of the district court (App. 26-31) are unreported.

JURISDICTION

The Court of Appeals filed its opinion and entered its judgment on December 2, 1997. App. 1. A petition for rehearing and suggestion for rehearing en banc was denied on March 3, 1998 (App. 24-25). The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

U.S. Constitution: Article I, §10; Art. III; 5th Amend.

42 U.S.C. §§1396a(a)(10)(E)(i),§1396a(a)(15) (repealed), §1396a(n), §1396d(p)(1), §1396d(p)(3).

Balanced Budget Act of 1997, Pub. L. 105-33, §4714.

California Welfare & Institutions Code §§14109, 14109.5

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[1] California Academy of Family Physicians; California Society of Anesthesiologists; California Urological Association; California Chapter of the American College of Emergency Physicians; California Chapter of the American College of Cardiology; California Society of International Medicine; California Society of Physical Medicine and Rehabilitation; California Radiology Society; Chapter of The American College of Radiology, Petitioners. There are no parent or subsidiary (other than wholly owned subsidiary) corporations of Petitioners.

STATEMENT OF THE CASE

I. Procedural History

In two separate actions (subsequently consolidated on appeal) in the United States District Court for the Central District of California, Petitioners challenged the California Medicaid ("Medi-Cal") program's refusal to pay its share of Medicare deductibles and co-insurance for medical services rendered by the Associations' members to patients known as Qualified Medicare Beneficiaries ("QMBs"). QMBs are patients who are "bought in" to the Medicare program by the state's payment of their Medicare premiums. At issue in these cases was whether certain 1986 and 1988 amendments to the Medicare and Medicaid Acts required the states to base their reimbursement obligation for such services to QMBs on the Medicare rate rather than the lower Medicaid rate. Jurisdiction for these actions was based on 28 U.S.C. §1331.

The district court granted summary judgments in favor of Petitioners, agreeing with and following the four circuits that had previously decided the same issue of statutory construction. App. 26-31. See *New York City Health and Hospital Corp. v. Perales*, 954 F.2d 854 (2nd Cir. 1992) *cert. den.* 113 S.Ct. 461 (1992) ("*Perales*"); *Pennsylvania Medical Society v. Snider*, 29 F.3d 866 (3rd Cir. 1994) ("*Snider*"); *Haynes Ambulance Service v. Alabama*, 36 F.3d 1074 (11th Cir. 1994) ("*Haynes*"); and *Rehabilitation Association of Virginia v. Kozlowski*, 42 F.3d 144 (4th Cir. 1994) *cert. den.* 116 S.Ct. 60 (1995) ("*Kozlowski*").

While appellants' appeals were pending before the Ninth Circuit, Congress passed the Balanced Budget Act ("BBA") of 1997, effective August 5, 1997. Pub. L. No. 105-33, 111 Stat. 251, *et seq.*. In response to these court decisions, Section 4714 of the BBA stated that its provisions were intended to "clarify" certain provisions of the QMB program (i.e., 42 U.S.C. §§1396a(n), 1396d(p)),[2] that were originally enacted in 1986, so

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[2] All subsequent statutory references will be to Title 42 of the United States Code unless otherwise noted.

as to permit states to eliminate or reduce payments for Medicare cost-sharing for QMBs by using lower Medicaid payment rates. The new provisions were made effective as of the date of enactment, August 5, 1997, *except* they were made *retroactive* as to payments by a state before the date of enactment if such payments were the subject of lawsuit based on the provisions of §§1396a(n) and 1396d(p) and pending as of or after August 5, 1997. 111 Stat.510.[3]

The Ninth Circuit recognized that if §4714 were to be characterized as a change in the law, "its retroactive application would pose a series of potential constitutional problems," since the medical services at issue had been provided before the 1997 amendments were passed. 132 F.3d at 1265. Nevertheless, the Ninth Circuit reversed the judgment below, holding that Supreme Court precedent required it to give "great weight" to congressional legislation that purported to express the "intent" of an earlier statute. Accordingly, while acknowledging that four circuit courts prior to the BBA "uniformly rejected [the] Secretary's reading" of the applicable statutes, 132 F.3d at 1266, it split with the other circuits and held that the Medicaid Act, as "clarified," by the Congress did permit the States to limit cost-sharing payments for medical services to QMBs at the Medicaid rate.

Appellants' Petition for Rehearing and Suggestion for Rehearing En Banc was denied on March 3, 1998.[4]

II. Summary of Issues Presented

At its core, this case involves the question of the proper construction of certain statutory provisions, originally enacted in 1986, defining the States' reimbursement obligation for Medicare

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[3] The Congressional Budget Office estimated that this provision which "overturns these decisions" would generate approximately $2.1 billion in net federal savings during 1998 through 2002. App. 47-48.

[4] The recent decision of the Seventh Circuit Court of Appeals in *Paramount Health System v. Wright*, 138 F.3d 706 (7th Cir. 1998), also deferred to the 1997 Congress' purported clarification.

services provided to QMBs under the Medicare and Medicaid Acts, an issue on which there is now a direct conflict among circuits which has enormous financial consequences for Petitioners' members. As a result of congressional action taken in 1997 while this case was pending on appeal, this case now presents a far broader constitutional issue arising from the Ninth Circuit's election to defer to Congress' purported "clarification" of the 1986 QMB legislation in the 1997 BBA, although (a) the Ninth Circuit's opinion offers no analysis of the meaning and intent of the 1986 legislation or of the reasonableness of the 1997 Congress' purported "clarification" of that legislation; and (b) to accord such deference required the Ninth Circuit to adopt a construction of the 1986 QMB legislation in direct conflict with the considered judgments of the four circuits that had previously considered the issue. As a result, this case now squarely presents the question as to the extent, and subject to what principles and standards, the courts should defer to congressional legislation purporting to clarify rather than amend earlier legislation enacted by a different Congress, especially where that purported clarification directly conflicts with intervening court decisions construing the earlier legislation and to apply that clarification retroactively would impair constitutionally-protected property rights.

A. Statutory Scheme

Because this case centers upon the proper judicial construction and interpretation of the statutes relating to the appropriate rate of reimbursement for providers of medical services to QMBs, a very brief summary of the QMB legislation and its statutory context is helpful.

Medicare. When Congress established the Medicare program in 1965 to ensure adequate medical care for the aged of this country, coverage was divided primarily into two parts, Part A covering all in-patient hospital expenses through an insurance plan, §§1395c-1395i-4, and Part B covering certain physician, ambulance, hospital, out-patient and other medical and health services not covered by Part A. §1395j-1395w-4(j). All Medicare-eligible patients receive Part A benefits. To be eligible for Part B benefits, however, Medicare-eligible patients must first enroll in the Part B insurance program by paying the Part B insurance premium. §1395o-1395s. After a Medicare-eligible

patient is enrolled in Part B, the federal government pays 80% of the Medicare allowable charge (§1395*l*), the patients themselves pay the remaining 20% of such charges, described as co-payments or co-insurance, as well as an annual deductible (§1395cc(a)(2)(A)). Together the Part B premiums, deductibles and 20% co-payments are referred to "Part B Cost-Sharing."

Medicaid. The Medicaid Act, which is designed to ensure medical services to the poor, establishes federal/state-funded program separate from Medicare, with the federal government overseeing the state's compliance with federal law (§1396c) and contributing approximately 50-80% of the funding with the states being responsible for the rest (§§1396b, 1396d(b)). States are not required to participate in the Medicaid program, but if they elect to do so, they must comply with the Medicaid Act and its implementing regulations. §1396c. Among other things, participating states must propose a plan that meets certain statutory requirements including the establishment of a schedule of Medicaid payment rates or reimbursement methods for the various kinds of medical care that a Medicaid patient may seek. §1396a(a)(30)(A).

Qualified Medicare Beneficiaries. For twenty years prior to 1986, states were required to make Medicare cost-sharing payments for dual-eligible individuals who were eligible for benefits under both Medicare and state Medicaid programs. 42 U.S.C. §1396a(15) (repealed). *See , infra*, at II.B.

In an effort to assure that the elderly poor received the full range of Medicare Part B services, Congress passed, as part of Omnibus Budget Reconciliation Act of 1986, the QMB amendments which are the focus of the present consolidated actions. Pub. L. No. 99-509, §9403, 100 Stat. 1874, 2053-55 (codified as amended) at §§1396a(a)(10)(E), 1396d(p), 1396a(n). These amendments gave states the option to use Medicaid funds to pay the Medicare Part B cost-sharing for a new category of Medicare-eligible individuals too poor to pay the Part B cost sharing on their own, but not poor enough to be Medicaid-eligible (§1396d(p)(1)). These individuals are commonly referred to as Qualified Medicare Beneficiaries or "QMBs." Section 1396a(a)(10)(E)(i) as originally enacted provided that a state Medicaid plan may provide "for making medical assistance available for Medicare cost-sharing (as defined in §1396d(p)(3) of

this title) for qualified Medicare beneficiaries described in §1396d(p)(1)." Section 1396d(p)(3) defines Medicare cost-sharing to include premiums, co-insurance and deductibles. States were required to cover these costs regardless of whether the same service could be covered under the state's Medicaid plan §1396d(p).

In addition, the 1986 amendments to the Medicaid Act provided that payment for QMBs would be subject to the provisions of newly-enacted §1396a(n), which clarified that "the total of Medicaid payments for Medicare cost-sharing charges together with Medicare payments may exceed the amounts otherwise payable under the State Medicaid plan for such services." H.R. Rep. No. 99-1012, 99th Cong., 2d Sess. 395-96 (1986), reprinted in 1986 U.S.C.C.A.N. 3868, 4040-4.

In 1988, Congress eliminated the states' option as to Part B Medicare services, amending §1396a(a)(10)(E) to *require* states to provide Medicare Part B benefits to pure QMBs. Pub. L. No. 100-360, §301(a)(1), 102 Stat. 683, 748. It also made all "dual eligibles," that is, patients eligible for benefits under both Medicare and Medicaid, in effect QMBs by repealing §1396d(p)(1)(B) (Pub. L. No. 100-647, §8434(a), 102 Stat. 3342, 3805), and §1396a(a)(15) (Pub. L. No. 100-485, §608(d)(14)(I), 102 Stat. 2343, 2416).

B. Federal Regulations and State Medicaid Manual

For almost two decades between 1971 and 1989, the Secretary's official policy -- contrary to the one she has assumed in this litigation -- was to require participating State Medicaid programs to pay, in addition to the Part B premium, the Part B 20% coinsurance and annual deductible amount for services provided to "dual eligible" beneficiaries under Part B. For example, in 1983, respondent Secretary issued a notice of proposed rule-making published in the Federal Register in which the agency's long-standing position was clearly set forth:

> Since 1971, HHS policy has been to require State agencies that have a "buy-in" agreement to pay, in addition to the Part B premium, the Part B coinsurance and deductible amount for services provided to beneficiaries under Part B, even if the services are not routinely provided under the Medicaid State Plan...In effect, if a State agency enters into a "buy-in"

> agreement, all the benefits under Part B have become part of the State plan for beneficiaries covered under the agreement.

48 Fed. Reg. 10378, 10379 (Mar. 11, 1983). See also 52 Fed. Reg. 47926, 47928 (Dec. 17, 1987).

In 1989, after the first actions were filed in the series of cases that resulted in the four Court of Appeal decisions pre-dating the 1997 Balanced Budget Act amendments, the DHHS Health Care Financing Administration ("HCFA") for the first time reversed its long-standing official position. Section 3490 of the revised guidelines for state Medicaid programs, set forth in the "State Medicaid Manual," purported to establish guidelines for the "Coverage of Qualified Medicare Beneficiaries For Medicare Cost Sharing Expenses." Under §3490.14, when a QMB incurs liability for services which are subject to the Medicare deductible or Medicare co-payments, the state's actual payment under the Medicaid reimbursement rate provided for in the State Plan is deemed payment in full for Medicare deductibles and co-insurance.[5]

C. California's Medi-Cal Program

California has elected to participate in the Medicaid program under the Medi-Cal Act. Welf. & Inst. Code, §§14000 et seq.; 22 Cal. Code Regs. §§50000 et seq. The state Medicaid plan provides for payment of the cost of any deductibles or cost sharing that QMBs may be entitled to under Medicare (Cal. Welf. & Inst. Code §14109) but limits the reimbursement rates for QMBs to the extent feasible to the Medi-Cal, rather than the Medicare, reimbursement rate. (Cal. Welf. & Inst. Code §14109.5.) With respect to payment for physician services under the Medi-Cal Program, the California Department of Health Services implemented this payment limitation for QMBs through Medi-Cal Services Bulletin No. 171 issued in 1989. Under said Bulletin, effective July 1, 1989, the combined Medicare/Medi-Cal

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[5] Two of the four circuit court opinions predating the BBA expressly declined to give deference to the Secretary's interpretation of the statutory provisions, in part, due to the inconsistency in the Secretary's position. *Snider*, 29 F.3d at 902; *Perales*, 954 F.2d at 862.

payment for all services of a claim may not exceed the amount allowed by Medi-Cal for all services of that claim.

HCFA approved the California Medicaid plan which purports to limit the reimbursement rate for QMBs to the Medi-Cal reimbursement rate. As a result, California's implementation of the QMB program caused Petitioners' members to receive no payments or dramatically lower payments for co-insurance and deductibles otherwise due them for services to QMBs.

III. Proceedings Below

The Associations challenged California's attempt to limit its reimbursement for Medicare services to QMBs to the Medi-Cal reimbursement rate. Since Medicare's payments of 80% of the Medi-Care-allowable charge virtually always exceeded the applicable Medi-Cal rate for the same service, Medi-Cal generally paid Petitioners' members $0 for the remaining 20% balance otherwise due under Medicare for their services.

Based on these facts, which were essentially undisputed, the district court granted Petitioners' summary judgment motion, finding that "Under the federal Medicare and Medicaid Acts, including but not limited to 42 U.S.C. §§1396a(a)(10)(E), 1395d(p)(1) and 1396d(p)(3), appellants' members, who provide medical services to qualified Medicare beneficiaries, are entitled to compensation for such services at 80% of the allowable medical rate plus full Medicare cost-sharing amounts." App. 26-30. The court further found that the amount of such cost-sharing is not limited by the Medi-Cal reimbursement rate for such services and to the extent California's statutes, regulations and bulletins provided to the contrary, they violated appellants' members' rights under the statutes cited above. App. 27, 30. Finally, the court noted that while it had considered independently all of the issues presented, it adopted the comprehensive analyses of the same statutes in *Perales*, *Snider*, *Haynes* and *Kozlowski*. The district court agreed with the four circuits rendering these decisions, "that the government's statutory construction would render the provisions of the Medicare and Medicaid Acts internally inconsistent and undermine the congressional purposes of the provisions in question." App. 27-28.

While the appeals of the Secretary and the State Director were pending, Congress enacted the Balanced Budget Act of

1997, §4714 of which addressed issues directly involved in this appeal by purporting to enact a "clarification" of §1396a(n) in response to the circuit court of appeals that had interpreted the prior statutory language. *See* H.R. Conf. Rep. No. 105-217, 105th Cong. 1st Sess. 870-71, *reprinted in* 1997 U.S.C.C.A.N. 176, 491-492 . Thus, subsection (a), entitled "Clarification Regarding State Liability for Medicare Cost Sharing," amended §1936a(n) by adding a new subparagraph (2) which provided that the payments made for Medicare cost-sharing by the states need not exceed the payment amount that would otherwise be made under the state Medicaid plan to an eligible beneficiary, and by adding a new subparagraph (3) prohibiting physicians and suppliers from "balance billing" an individual QMB to the extent that a state does not pay the full Medicare cost-sharing amount. 111 Stat. 510. The Ninth Circuit consolidated the appeals of five cases involving the same statutory construction issues, and requested and received supplemental briefing upon the effect of §4714 on the cases pending before it.

On December 2, 1997, the Ninth Circuit filed its decision reversing the district court's judgment. Seeing the resolution of the issue as relatively simple, the Ninth Circuit began its discussion by "eschew(ing) any analysis of [the] original arguments and turned instead to the validity and applicability of the 1997 enactment." 132 F.3d at 1264. Regarding the cases before it or still "pending," the court held that, "Because Congress has . . . the authority to *change* the law as to pending cases, its power to *clarify* the law -- to confirm what the law has always meant—follows a fortiori." *Id.* at 1265.

Relying on this Court's decisions in *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381-382, n. 8 (1969) and *Loving v. U.S.*, 517 U.S. ____, 116 S.Ct. 1737, 1749, 135 L.Ed.2d 36, 57 (1996), the Ninth Circuit accepted the proposition that congressional legislation clarifying or interpreting the intent of an earlier statute must be accorded "great weight." It attempted to distinguish other cases that rejected the competence of a later Congress to opine on the meaning of an earlier statute on the ground that those cases involved less formal types of legislative history, such as House and Senate reports, rather than formal legislation from Congress as a body. 132 F.3d at 1265.

The court then justified its deference to Congress' 1997

"clarification" of the 1986 QMB legislation on the ground that it found the earlier statutory language "baffling" and lacking any clearly established meaning before §4714 was adopted. The court disregarded the unanimous judgments of the Second, Third, Fourth and Eleventh Circuits, as well as their uniform rejection of the Secretary's interpretation of the statute (which Congress embodied in §4714), on the grounds that (with the exception of *Haynes*, which followed *Snider*), they appeared to use different rationales to support their respective opinions. 132 F.3d at1266. The Ninth Circuit's opinion contains no discussion of the language, legislative history or the intent of the 1986 legislation that originally established the state's obligations under the QMB program, nor does it attempt to explain how the 1997 "clarification" comports with the purposes of this original legislation. Nevertheless, the Ninth Circuit concluded it should "honor Congress 'clarification' label and accept. . . §4714's provisions as a statement of what Section 1396a(n) has meant all along." 132 F3d at 1266. It reversed the district court's judgments in favor of Petitioners, thereby mooting Petitioner's constitutional claims. *Id.*.

A. The Seventh Circuit's *Paramount* Decision

On March 19, 1998, only a few months after the Ninth Circuit's decision, the Seventh Circuit decided the identical issue of law in *Paramount Health Systems, Inc. v. Wright*, 138 F.3d 706. ("*Paramount*") (1998). In *Paramount*, the Seventh Circuit recognized that, prior to Congress' 1997 clarifying amendments, four circuits had unanimously found that the 1986 QMB legislation unambiguously required the states' reimbursement obligation to be based on the Medicare rather than Medicaid rates, and had unanimously rejected the Secretary's position as entirely untenable. Further, the court seriously questioned whether §4714 of the 1997 Balanced Budget Act represented a *bona fide* clarification of the 1986 QMB legislation, observing that it was included in a statute principally concerned with cutting the federal budget, and that it was passed 11 years after the 1986 QMB legislation by a Congress whose membership had substantially turned over in the intervening years and whose veteran members would be unlikely to remember what the 1986 Congress' intention had been regarding the "esoteric issue" of the reimbursement rate

for medical services to QMBs. The court also noted that nothing in the 1997 provisions themselves suggested a process of interpretation, "they merely declare that the states are not required to reimburse QMB providers at the Medicare rate," citing *SEC v. Sloan*, 436 U.S. 103, 118, (1978) (thoroughness evident in agency's consideration and validity of its reasoning are factors for court to consider in evaluating persuasive force of ruling). 138 F.3d at 710. In view of these factors, the Seventh Circuit found particularly apropos this Court's holding that, "[T]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one," citing *United States v. Philadelphia Nat. Bank*, 374 U.S. 321, 348-349 (1963) and *South Dakota v. Yankton Sioux Tribe*, ____ U.S. ____, 118 S.Ct. 789, 803-804 (1998) 138 F.3d at ___. Accordingly, the court suggested that a "far more realistic" view was that §4714 was designed to change the original 1986 legislation in order to reduce the cost of Medicaid to the federal government. *Id.* at 710.

Nonetheless, Judge Posner noted that this Court, somewhat contradictorily, had also declared that subsequent legislation "declaring the intent of an earlier statute is entitled to great weight in statutory construction," citing *Loving*, *Red Lion* and *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 118, n. 13 (1980) ("*GTE Sylvania*"). Judge Posner stated that he was unable to reconcile the *Loving* line of cases with the *Philadelphia Nat. Bank* line of cases, holding that the views of a later Congress form a hazardous basis for inferring the intent of an earlier Congress. Implicitly rejecting the Ninth Circuit's rationale, Judge Posner noted that the principles articulated in the latter line of cases had been employed not only in cases involving mere legislative materials, committee reports, and the like, but also in cases involving subsequent legislation, including *Yankton*, which Judge Posner described as the "Supreme Court's latest word on the subject." 138 F.3d at 711.

As a consequence, the Seventh Circuit found itself in a "quandary" over the continued vitality of *Loving* and expressly invited clarification from this Court. Pending such clarification, however, and although acknowledging that the providers had the "better interpretation" of the original statute, the Seventh Circuit felt constrained to give enough weight to the 1997 Congress' declaration of intent to "tip the balance in favor of Chevron

deference" and, accordingly, also reversed the district court judgment for the providers. *Id.*

REASONS FOR GRANTING THE PETITION

Review is necessary in this case for a host of reasons. First, six of the circuit courts of appeals are directly split as to the proper interpretation of important provisions of the Medicare and Medicaid Act defining the reimbursement obligations of the states for Medicare services provided to QMBs. (*McElroy v. U.S.*, 455 U.S. 642 (1982) (conflict among the circuits a strong basis for review).) Second, resolution of the statutory construction issue also implicates an important jurisprudential question, i.e., what weight, if any, should the courts accord to a later Congress' declaration as to the meaning or intent of legislation enacted by an earlier Congress, an issue on which this Court's decisions are seemingly diametrically inconsistent, and the answer to which this Court has already recognized "is not free of ambiguity." *McDaniel v. Sanchez*, 452 U.S. 130, 138 (1981). This question is important because of the increasing frequency of Congress' use of the "clarification" device when amending federal legislation.[6] This question is especially important here because, if §4714 plainly constitutes a change in rather than a clarification of the 1986 QMB legislation, its retroactive application to deny reimbursement to providers for medical services already rendered to patients under the QMB program impairs their protected property rights to payment for these services in violation of Article 1, §10, and the "takings" clause of Amendment V to the U.S. Constitution.

I. Review Is Necessary To Resolve A Dispute As To The Meaning And Intent Of The Statutory Scheme Defining The States' Obligation To Reimburse Health Care Providers For Medicare Services Previously Rendered On Which Issue The Decisions Of The Ninth

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[6] The 1997 BBA itself contains no less than 17 "clarifications" of previously enacted legislation. App. 40-42.

And Seventh Circuits Directly Conflict With Those Of The Second, Third, Fourth and Eleventh Circuits.

Centrally at issue in this case is the meaning and intent of the QMB legislation, as enacted by Congress in 1986. The resolution of this question is unquestionably a judicial, not legislative, function. *Pierce v. Underwood*, 487 U.S. 552, 566 (1988) ("it is the function of the courts and not the Legislature . . . to say what an enacted statute means"); *Marbury v. Madison*, 5 U.S. 137 (1803). In determining the meaning and intent of the 1986 QMB legislation, the Second, Third, Fourth and Eleventh Circuits each engaged in an independent examination of the relevant statutes and their legislative history, available judicial precedent and the historical and contemporary administrative constructions of the statutes before concluding that Congress clearly and unambiguously intended to define the States' reimbursement obligation for Medicare services to QMBs based on the Medicare, not Medicaid, rates.

In sharp contrast, neither the Ninth Circuit in this case nor the Seventh Circuit in *Paramount* engaged in any such analysis. Rather, in concluding that the 1986 QMB legislation permitted the States to limit their reimbursement share for Medicare services to QMBs to lower Medicaid rates, the Ninth Circuit uncritically deferred to the 1997 Congress' purported "clarification" of the statutory scheme. Its opinion contains no analysis of either the meaning and intent of the 1986 legislation or the reasonableness of the 1997 "clarification," nor any consideration of the considered analyses and directly contrary judgments of the Second, Third, Fourth and Eleventh Circuits. The Seventh Circuit's *Paramount* decision is more considered, and clearly more troubled by the judgment it felt compelled to reach. Ultimately, however, that court also deferred to the 1997 Congress' purported "clarification" of the 1986 QMB legislation, issuing nothing more than a passing discussion of the meaning and intent of the 1986 legislation and entirely disregarding the analyses of the earlier four circuits, which demonstrated that the construction of the 1986 legislation advanced by the 1997 Congress, as then asserted by the Secretary, was not even a "reasonably possible" interpretation of the statutory scheme. *See Chevron USA v. Natural Res. Def. Council*, 467 U.S. 837, 843-844 (1984).

As discussed below, the Ninth and Seventh Circuit opinions squarely present the important jurisprudential question whether, and subject to what principles and standards, the courts should defer to a later Congress' interpretation of earlier enacted legislation in performing their Article III function to interpret that earlier legislation. The proper construction of the 1986 legislation governing the measure of the States' obligation to share in the reimbursement of providers of Medicare services to QMBs remains an independently important issue profoundly affecting the fiscal stability and viability of providers in the state of California.

The Ninth Circuit's deference appears to be in fact an abdication of its Article III duty to interpret the legislation at issue before it. Nothing in the opinion reveals the results of the court's own independent efforts to determine the intent of the 1986 Congress other than its assertion that ascertaining Congress' intent in enacting §1396a(n) would be difficult. But difficulty alone does not relieve the courts of their independent duty to ascertain the meaning of a statute. In *Perales*, the Second Circuit noted that, despite the complex nature of the statutory scheme, it had a duty to use the ordinary tools of statutory construction such as the text, structure and history of the legislation at issue to discover its purpose; and where the process identified a purpose clearly at odds with a proffered administrative interpretation, not to defer to it. *Perales*, 954 F.2d at 862-3. Here, the Ninth Circuit's opinion fails to analyze why the 1986 Congress enacted the QMB legislation, how §1396a(n) fits into the legislative plan, and how or why it concluded that the 1997 Congress's interpretation, without the benefit of an analysis of the 1986 legislation, reasonably effectuated the 1986 Congress's intent. *Cf. Universities Research Assn. v. Coutu*, 450 U.S. 754 (1980).

Unlike the Ninth Circuit, the Seventh Circuit recognized the "unreality" of giving great weight to the 1997 Congress' view of the 1986 Congress' intent, where the purpose of §4714, as part of the Balanced Budget Act, was to reduce the cost of Medicaid and the provision lacked any explanation as to how the 1997 Congress had determined the intent of the 1986 Congress. 138.F.3d 710. Nonetheless, believing §1396a(n) to be ambiguous and, believing itself bound to some extent by the *Loving* precedent, the Seventh Circuit, gave sufficient deference to

Congress' clarification to tip the scale toward *Chevron*-like deference in favor of the government's position.

The Seventh Circuit's analysis, however, is flawed. Even assuming that §1396a(n) is ambiguous, which none of the four earlier circuits found to be the case, that fact does not compel automatic deference to Congress' position. In order to fulfill their Article III duties, the courts must still determine whether Congress' position represents a *reasonable* interpretation of the statute. *Cf. Chevron*, 467 U.S. at 843-844. As this Court stated in *SEC v. Sloan*, 436 U.S. at 118, "the courts are the final authorities on issues of statutory construction and are not obliged to stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute." Here, the four other circuits after analyzing the purpose and intent of §1396a(n) each considered and specifically rejected the Agency's position as unreasonable.[7] Yet the Seventh Circuit paid little heed – and the Ninth Circuit unfortunately paid no heed -- to their analysis when confronted with precisely the same construction in §4714.

The four earlier circuit decisions, however, recognized that QMBs were Medicare, not Medicaid, patients, and that the 1986 legislation was designed to provide Part B Medicare coverage they were too poor to obtain for themselves, but which "dual eligibles" were already receiving from the States under §1396a(a)(15). See 48 Fed.Reg. 10378, 10379 (Mar. 11, 1983); *Perales*, 954 F.2d at 860. The Secretary's interpretation of §1396a(n) frustrated that intent.

When Congress enacted the QMB statutes in 1986, medical services providers who did not take an assignment from their Medicare patients could bill the patients for the balance due

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[7] See *Perales*, 954 F.2d at 858 (Secretary's interpretation "at odds with the *clear* intent of the statutes, both facially, and as elaborated by legislative history"); *Kozlowski*, 42 F.3d at 1459 (rejecting Secretary's position because "there can be no doubt" as to statutory meaning); *Snider*, 29 F.3d at 901-902 (finding that Secretary's interpretation defeated congressional intent underlying the QMB program); *Haynes*, 36 F.3d at 1076 (same).

after Medicare paid its 80% of the covered cost. Because it would generally be difficult, if not impossible, for QMBs to pay the balance due, the 1986 statutes were designed to transfer this financial burden to the State. As the Third Circuit recognized, this purpose clearly appears from the contemporary House Report explaining the program:

> For elderly and disabled individuals whom the State chose to cover, the Medicaid program would pay for the Part B deductible and the beneficiary's 20 percent coinsurance on Part B services. If the beneficiary uses a physician who takes assignment, Medicaid would pay the physician directly for the 20 percent coinsurance and the patient could not be billed for any amounts above the Medicare reasonable charge. However, if the physician elects not to take assignment, the beneficiary would submit the claim for the 20 percent coinsurance requirement to the State Medicaid program and would be liable for an additional amount charged by the physician.

H.R. Rep. No. 99-727, 99th Cong., 2d Sess. 106 (1986) reprinted in 1986 U.S.C.C.A.N. 3607, 3696; *see Snider*, 27 F.3d at 901.

The Secretary's position that Section 1396a(n), by implication, was intended to limit the State's obligation to the Medicaid rate obviously contravenes the purpose of the statute. If the State paid only the Medicaid rate, QMBs would be liable for the entire amount due under the Medicare reimbursement principles even if their physicians accepted assignments, which they had no obligation to do. The net result, of course, is that QMBs would again bear the obligation to pay the balance of the bill – the exact outcome Congress intended to avoid. *Cf.*, *Snider* at 901.

Snider, *Perales*, *Haynes* and *Kozlowski* construed §1396a(n) as an authorization to make payments for QMB services at the Medicare rate rather than at the Medicaid rate required to be set forth in the State plan. *Snider* observed that §1396a(n) could be reconciled with §1396a(10)(E)(i) by construing it to authorize the States to pay more than the Medicaid rates, while the Secretary's contention that §1396a(n) authorized the States to limit payments for QMBs would do "irreconcilable harm" to §1396a(10)(E)(i)'s mandate of full

payment of Part B cost sharing. *Snider*, 29 F.3d at 896; *Perales*, 954 F.2d at 859-60.

The Seventh Circuit questioned this analysis on the grounds that if §1396a(a)(10)(E)(i) clearly entitled providers to full Medicare reimbursement rates, the States could hardly be penalized for such reimbursements, and that since the beginning of Medicare and Medicaid, providers of services to dual-eligibles had been paid at the Medicare rate without any threat of penalties. Even if correct, this observation does not diminish the validity of *Snider's Perales'* and *Haynes'* interpretation of §1396a(n). First, there appears to be no reason why Congress could not make specific by §1396a(n) that which is implied by §1396a(a)(10)(E)(i), i.e., that payment of Medicare rates is authorized even if they exceed the stated Medicaid rates.. Indeed, the Conference Report indicates that was precisely the purpose of §1396a(n):

> (c)Payment amounts – Provides that the total of Medicaid payments for Medicare cost-sharing charges under this provision together with Medicare payments may exceed the amounts otherwise payable under the State Medicaid plan for such services.

H.R. Conf. Rep. No. 99-1012, 99th Cong., 2d Sess., 395-96 (1986) reprinted in 1986 U.S.C.C.A.N. 3868, 4040-4041. As *Snider* noted, "(t)his language emphasizes the comparison between Medicare and Medi-Cal rates of payment, rather than the discretion of the states" to eliminate or reduce cost-sharing payments. *Snider*, 29 F.3d at 895. Second, the QMB program was new, separate and distinct from the ongoing "dual-eligible" program, so precedent from the latter was not necessarily controlling as to the former. Finally, as already noted, the Secretary's interpretation directly contravened the intent of the statute, by ultimately placing the burden of Part B cost sharing on the very aged poor whom the law was intended to benefit. *Id.*, at 901.

In sum, totally missing from the Seventh and Ninth Circuits' opinions is any explanation as to how construing the 1986 QMB legislation to allow States to limit their obligatory share of the costs of Medicare services to QMBs to the Medicaid rate in any way furthers the 1986 Congress' intent to make otherwise unaffordable Medicare services available to QMBs.

Since the Secretary's interpretation of the statute necessarily yields a result directly contrary to that Congress intended, i.e., with the QMBs responsible for the entire unpaid balance, the Second, Third, Fourth and Eleventh Circuits properly rejected it as an entirely untenable construction of the 1986 legislation. The 1997 Congress' "clarification" of that legislation, which is identical to the Secretary's interpretation that the courts have universally rejected as unreasonable, should not command any greater deference.

II. Review Is Necessary To Resolve An Apparent Conflict Among This Court's Decisions And To Clarify The Principles And Standards Governing The Deference, If Any, The Courts Should Give A Subsequent Congress' "Clarifications" Of Legislation Enacted By An Earlier Congress. Under Any Standard of Deference, The Ninth Circuit's Deferral To The 1997 Balanced Budget Act "Clarification" Of The 1986 Medicare Legislation Was Unwarranted.

The Ninth and Seventh Circuits ultimately reached their judgments as to the meaning of the 1986 QMB legislation only by giving conclusive weight to the 1997 Congress' purported "clarification" of the meaning of that earlier legislation. This Court's cases, however, appear to state two diametrically opposed rules as to the proper weight to be given to such subsequent congressional expressions, an inconsistency that left a respected Seventh Circuit in a "quandary" and led it to expressly request clarification from this Court on the issue.

As already noted, "it is the function of the courts and not the Legislature ... to say what an enacted statute means." *Pierce*, 487 U.S. at 566.[8] As a corollary to this basic principle, this Court

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[8] As this Court observed over 100 years ago: "'In this country, where the legislative power is limited by written constitutions, declaratory laws, so far as they operate upon vested rights, can have no legal effect on depriving a individual of his rights or to change the rule of construction as to pre-existing law. . . . [T]hey can have no binding effect; and if the judge is satisfied the legislative construction is wrong, he is bound to disregard it.'

(continued...)

has observed that it is the intent of the enacting Congress, not the views of a later Congress, that controls the courts' construction of an enacted statute. *See, e.g., Public Employees v. Betts*, 492 U.S. 158, 168 (1989); *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979).

Accordingly, this Court has frequently stated unequivocally that the views of a subsequent Congress on the meaning of legislation enacted by an earlier Congress has little, if any, significance. *See, e.g., Yankton*, 118 S.Ct., at 803-04; *Public Employees v. Betts*, 492 U.S. at 168 ("We have observed on more than one occasion that the interpretation given by one Congress . . . is of little assistance in discerning the meaning of [a prior] statute"); *Gwaltney v. Chesapeake Bay Foundation*, 484 U.S. 49, 63 fn. 4 (1987) (rejecting 1987 Congress' view of 1982 Clean Water Act: "The conclusions of the 99th Congress ... are hardly probative of the intent of the 92nd Congress"); *U.S. v. Price*, 361 U.S. 304, 313 (1960) (1946 Congressional interpretation of 1939 Internal Revenue Code "form a hazardous basis for inferring the intent of an earlier [Congress]"); *Rainwater v. U.S.*, 356 U.S. 509, 593 (1958) (Congress' 1918 interpretation of 1863 False Claims Act "has very little, if any significance").[9]

On the other hand, this Court has also asserted that such

(...continued)

(T)o declare what the law is, or has been, is a judicial power, to declare what the law shall be is legislative, and that one of the fundamental principles of all our governments is, that the legislative power shall be separate from the judicial, this court interrupted them with the observation that it was unnecessary to argue that point." *Koshkonong v. Burton*, 104 U.S. 668, 26 L.Ed. 886, 890 (1882) (*emphasis added*); see also *Stockdale v. Atlantic Ins. Co.*, 87 U.S. 323, 22 L.Ed. 348, 351 (1874).

[9] Additional cases finding a later Congress' views a "hazardous basis" for inferring earlier legislative intent include: *Philadelphia Nat. Bank*, 374 U.S. at 349-349; *O'Gilvie v. U.S.*, 519 U.S. _____, 117 S.Ct. ____, 136 L.Ed. 454, 464 (1996); *U.S. v. X-Citement Video, 513 U.S. _____, 115 S.Ct. 464,* 130 L.Ed.2d 372, 384 n.6 (1994); *Central Bank of Denver, N.A. v. First Interstate Bank of Denver,* 511 U.S. 164 (1984), *U.S. v. Texas,* 507 U.S. 511, 535 n. 4 (1993).

subsequent congressional views are entitled to "great weight" in interpreting the meaning of earlier enacted legislation. *See, e.g., Loving v. U.S.*, 116 S.Ct. at 1749..[10]

The Ninth Circuit attempted to harmonize these seemingly conflicting lines of cases on the basis that those that questioned the competence of a later Congress to opine on the intended meaning of an earlier statute did not involve Congress acting as a body, but rather involved less formal types of subsequent legislative history such as Senate and House Committee reports. But as Judge Posner observed in *Paramount*, that postulated distinction breaks down in view of this Court's cases rejecting subsequent Congressional views that do involve the entire Congress. *See, e.g., Public Employees v. Betts*, 492 U.S. at 168; *Gwaltney*, 484 U.S. at 63 n. 4; *Price*, 361 U.S. at 313; Rainwater, 356 U.S. at 593. Indeed, the Ninth Circuit apparently recognized, but then inexplicably ignored, that its own attempted distinction fell short when it expressly noted that, in *Mackie v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), this Court had rejected not only a House Committee report, but also the later statutory enactment of that report as a basis for inferring the intent of an earlier Congress.

The Seventh Circuit was far more troubled than the Ninth Circuit by the doctrinal uncertainty caused by these apparently conflicting principles under these two lines of cases. The Seventh Circuit's disturbance was warranted. As Judge Posner observed, these lines of cases are seemingly irreconcilable on a doctrinal level. 138 F.3d at 711. Moreover, the issue is presenting itself with increasing frequency. The 1997 Balanced Budget Act itself contains no less than 17 purported "clarifications" of previously enacted legislation. App. 40-42. Indeed, only recently this Court

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[10] Additional cases giving "great weight" to an earlier Congress' declaration include: *GTE Sylvania, Inc.*, 447 U.S. at 118 n. 13; *Red Lion*, 395 U.S. at 380-381; *Federal Housing Adm. Darlington, Inc.*, 358 U.S. 84, 90 (1958); *Gladden Co. v. Zdanok*, 370 U.S. 530 (1962); *Seatrain Shipbuilding Corp. v. Shell Oil Co.*, 444 U.S. 572 (1980); *Bell v. New Jersey*, 461 U.S. 773 (1983); *Gozlon Peretz v. U.S.*, 498 U.S. 395 (1991); and *Bufferd v. Commissioner*, 506 U.S. 523 (1993).

granted certiorari and remanded to the Seventh Circuit Court of Appeals a case presenting precisely this issue arising out of the 1997 Balanced Budget Act. *See Doherty v. Pennington*, _____ U.S. _____, 139 L. Ed.2d 225 (1998), rev'g mem. 110 F.3d 502 (7th Cir. 1997). Especially when coupled with the direct split among six of the circuits on the underlying important statutory construction issue, therefore, this doctrinal uncertainty on a matter going to the heart of the principles on which the separation of legislative/judicial powers doctrine rests strongly supports this Court's review in this case.

That in deferring to Congress' 1997 "clarification" both the Ninth and Seventh Circuits failed to fulfill their Article III duty to independently determine the meaning of the 1986 legislation, underscores the need for this Court's review. The Ninth Circuit's apparent avoidance of this responsibility is particularly disturbing because it rests on a misconception of the nature of the 1997 congressional action. As the basic premise of its analysis, the Ninth Circuit states that "[b]ecause Congress ... has ... authority to *change* the law as to pending cases, its power to *clarify* the law – to conform to what the law has always meant – follows a fortiori." 132 F.3d at 1265 (emphasis in original). Whatever authority Congress may have to clarify a law, however, cannot be viewed as merely subsumed within Congress' power to legislate, because it involves a distinctly different, in fact judicial, function. Proceeding from this flawed premise, the Ninth Circuit's decision failed to independently determine for itself either the meaning and intent of the 1986 QMB amendments, or whether §4714, which embodied the Secretary's consistently rejected interpretation of the earlier legislation, was in any way a tenable reading of the legislation.

Furthermore, the nature of the 1997 amendments strongly negates any basis for deference in this case. As Judge Posner explained in *Paramount*, nothing in the context of the Congress' enactment of §4714 indicates that it was anything other than a material change in the 1986 legislation. Congress enacted §4714 as part of the 1997 Balanced Budget Act, for the express purpose of reducing expenditures and overturning the decisions of the Circuit Courts that had specifically rejected the substance of Congress' "clarification" as advanced by the Secretary. As this Court has long recognized, Congress' attempt to overturn

intervening judicial constructions of legislation by means of subsequently enacted interpretations of the earlier legislation are ineffective. *See Koshkonong*, 26 L.Ed. at 890 (later Congress' interpretation of a statute previously construed by the courts "can have no legal effect in depriving an individual of his rights, *or to change the rule of construction as to a pre-existing law*") (emphasis added); see also *U.S. v. Wise*, 370 U.S. 405, 414 (1962) (no weight given to how members of the 1914 Congress may have interpreted the Sherman Act as enacted in 1890).; *cf., Stockdale*, 22 L.Ed. at 351 (1870 legislation construing intent of 1864 tax statutes upheld because construction "was not in . . . essence at attempt to construe a statute differently from what the courts had construed it").

The 1997 Congress' purported clarification of the 1986 legislation to permit the states to limit their Medicare reimbursement obligation for services to QMBs to the Medicaid rate was in substance the same interpretation of that legislation that the Secretary had earlier advanced and which the four earlier cases had unequivocally rejected as untenably inconsistent with the intent of the 1986 legislation. Indeed, as already noted, the four earlier circuit decisions expressly refused to give any weight to the Secretary's interpretation, as would otherwise be required by *Chevron*, 467 U.S. 837, precisely because those courts each found the Secretary's interpretation to be contrary to the clear intent of the enacting Congress. *See fn.7, supra.*

Numerous other factors, many of which Judge Posner identified in *Paramount*, also militate against according any deference, let alone great weight, to the 1997 Congress' clarification of the 1986 legislation. Indeed, this Court has recognized these factors as a proper basis for declining to defer to a subsequent legislative view of an earlier Congress' legislative intent. These factors include:

1. The lapse of 11 years between the 1986 QMB legislation and the 1997 Balanced Budget Act: *Cf., U.S. v. Wise*, 370 U.S. at 413 (no deference to 1914 Congress interpretation of 1890 Act).

2. The turnover of the membership in Congress during this 11 year interval and the 1997 Congress' lack of knowledge of or insight into the intent of the 1986 members on the issue of QMB reimbursement. *Cf. U.S. v. United Mine*

Workers, 330 U.S. 258, 281-282 (1946) (Senators' opinion in 1943 not authoritative where they entered Senate after enactment of 1932 legislation).

3. The circumstances surrounding the enactment furnished no basis for inferring that Congress' clarification had been "courtlike," i.e., suggesting a process of interpretation, where §4714 had been passed as part of the 1997 Balanced Budget Act, which was primarily concerned with cutting the federal deficit. *Paramount*, 138 F.3d at 710.

4. The 1997 legislation was "litigation inspired," as evidenced by its express application to pending cases (an unnecessary expression if the §4714 applied only clarified earlier legislation), rather than constituting a direct response to the four circuit decisions which had been rendered 3-5 years earlier.

5. Deferring to the 1997 amendments as a clarification, rather than a retroactive change in the applicable law governing reimbursement to QMBs, is particularly unwarranted where the later Congress' interpretation of the earlier statute impairs or violates constitutionally protected rights. *Stockdale*, 22 L.Ed. at 351; *Koshkonong*, 26 L.Ed. at 890.

Given the coalescence of the factors summarized above, this case presents the precise circumstances under which a later Congress' views provide a hazardous basis indeed for inferring the intent of earlier legislation. The seriousness and importance of the jurisprudential and separation of powers issues implicated by the Ninth and Seventh Circuit decisions strongly support review in order to clarify the law governing the deference, if any, the courts owe to the views of a subsequent Congress regarding earlier enacted legislation.

III. Section 4714's "Clarification" Of §1396a(n) Violates The Separation Of Powers Doctrine

To the extent §4714 of the Act purports to clarify §1396a(n), it runs afoul of the doctrine of separation of powers that underlies Article III. Under that doctrine, a court will construe as unconstitutional legislation enacted by Congress which prescribes a rule of decision in a case pending before the court in a manner that requires the court to decide the controversy in the Government's favor. *U.S. v. Klein*, 13 Wall 128, 20 L.Ed. 519 (1872); *U.S. v. Sioux Nation of Indians*, 448 U.S. 371, 404

(1980). Here, prior to the enactment of the Act, four circuit courts had unanimously agreed that §1396a(n) did not allow the states to limit Medicare cost sharing to the Medicaid rate and had specifically rejected the Government's contrary interpretation of the statute as contrary to the 1986 Congress' intent. In effect, newly added §1396a(n)(2) now mandates that the Government's previously rejected position be accepted.

Thus, Congress in effect has prescribed the new rule of decision as to §1396a(n) cases, but that rule operates not only prospectively, but under the express provision of subsection (c) of §4714, is made retroactive to apply to payments by a state for items and services furnished before such date "if such payment is the subject of a lawsuit that is based on the provisions of sections 1902(u) (§1396a(n)) and 1905(p) (§1396d(p))."

By thus "clarifying" §1396a(n) to give it an interpretation which the Government had previously advocated, but which the courts had previously rejected and then making its provisions retroactive as to all pending litigation, the Government has assured that any court now confronted with the controversy will be required to decide it in the Government's favor. And the Government has done this through a law that in its retroactive aspects is not a law of general application, but rather operates only as to pre-Act payments that are the subject of §1396a(n) lawsuits pending as of or initiated after the date of the Act's enactment, i.e., August 5, 1997. *Klein* and *Sioux Nation* preclude such a result.

The Ninth Circuit recognized exactly what Congress intended to do. "What is . . . significant is that Congress' characterization plainly reflects its intention to resolve every still-live dispute in the manner specified by the new legislation." (132 F. 3d at p. 1264.) The court might have added "i.e., in the Government's favor." Yet, the Court concluded that since "Congress has authority . . . to *change* the law as to pending cases, its power to clarify the law – to *confirm* what the law has always meant – follows a fortiorari." 132 F.3d at 1265.

This statement is fundamentally flawed. While Congress has the power to *amend* the law and make such a change retroactive, such power is subject to express constitutional limits, such as the prohibition against "impairing the Obligations of Contracts" (Art., §10, cl.1), or against depriving private persons

of vested property rights except upon payment of "just compensation" (Fifth Amendment's Taking Clause). *Landgraf v. USI Film Products*, 501 U.S. ____, 128 L.Ed.2d 229, 253 (1994); *cf. U.S. v. Schooner Peggy*, 1 Cranch 103, 110, 2 L.Ed.49, 51 (1801). However, it is equally clear that Congress does not have power to attempt to sidestep these fundamental constitutional limitations by "confirm(ing) what the law has always meant" because "to declare what the law is, or has been, is a judicial power, to declare what the law shall be is legislative, and one of the fundamental principles of all our governments is, that the legislative power shall be separate from the judicial . . ." *Koshkonong*, 104 U.S. 668, 26 L. Ed. 886, 890; *see also Stockdale*, 87 U.S. 323, 22 L.Ed. 348, 351.

To the extent therefore that Congress' "clarification" purports to "confirm" what §1396a(n) "has always meant," it usurps a power that resides solely in the judiciary.

IV. Review Is Necessary Here Because The Retroactive Application Of The Substantial Amendments To The 1986 QMB Legislation Effected By §4714 Of The 1997 Balanced Budget Act Unconstitutionally Impairs Substantial Protected Property Rights.

As the preceding discussion makes clear, §4714 of the 1997 Balanced Budget Act fundamentally alters, rather than narrowly clarifies, the 1986 QMB legislation pertaining to State reimbursement for Medicare services provided to QMBs. As four courts of appeals have unanimously concluded, the 1986 legislation required States to reimburse providers at Medicare rates rather than permitting the States to cap their reimbursement obligation at the substantially lower Medicaid rates. Section 4714 reverses that limitation and explicitly permits States to cap their reimbursement obligation at Medicaid, not Medicare rates.[11]

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[11] Other additions by §4714 underscore the fact that §1396a(n) was being changed, not clarified. Subparagraph (a)(2) (111 Stat.510) prohibits a provider from "balance billing" a beneficiary for the amount of the 20% coinsurance or deductible eliminated under the new Medicaid payment cap, whereas the prior statute, although providing for assignment, did not cap the

(continued...)

Section 4714(c) selectively applies the amendments' provisions retroactively only to litigation pending on or initiated after the Amendment's effective date so as to deny providers full reimbursement for services already provided to patients. This Court has established a strong presumption against retroactivity and has made abundantly clear that the retroactive application even of ordinary legislation requires careful scrutiny so that the public's constitutionally protected rights and legitimate expectations are not adversely impaired. *See, e.g., Landgraf v. USI Film Products*, 511 U.S. ___, 114 S.Ct. 1483, 128 L.Ed.2d 229, 252-53 (1994); *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 208 (1988). The retroactive application of §4714 falls squarely within this doctrinal caution, for its application here plainly deprives providers of vested contractual rights to reimbursement for services previously rendered in direct violation of the Takings Clause of the Fifth Amendment to, and impairs fixed contractual rights in violation of Article 1, Section 10 of, the U.S. Constitution.

First, this Court has recognized that "[r]rights against the United States arising out of a contract with it are protected by the Fifth Amendment." *Lynch v. U.S.*, 292 U.S. 571, 579 (1934). As a corollary to this principle, "[w]hen the United States enters into contract relations, its rights are governed generally by the law applicable to contracts between private individuals." *Id.*, quoted with approval in *United States v. Winstar Corp*, 518 U.S. ___, 135, 116 S.Ct. ____, L.Ed.2d 964, 1004 (1996) (plurality opinion) ("*Winstar*").

Here, the relationship between health care providers and the federal and state governments within the Medicare and Medicaid structure is undisputedly contractual, an essential term of which is the providers' right to full reimbursement for their Medicare-allowed costs (including Medicare cost-sharing for services rendered to "dual eligibles"). *See Perales*, 954 F.2d at 858; *Stephenson v. Shalala*, 87 F.3d 350, 352 (9th Cir. 1996) (the

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(...continued)
payment due the provider. *See Snider*, 29 F.3d at 900.

"80-20" cost-sharing arrangement "*guarantees* health services providers payment for 100% of their Medicare-allowed costs") (emphasis added).

In describing this contractual relationship and the function of the Medicare Provider agreements under it, the courts have explained that "(t)he Provider agreement is a unique type of contract. It does not provide for a defined transaction or even a series of transactions. It simply establishes a relationship between the parties: *if [the provider] treats eligible patients, HHS will reimburse them for their costs.*" *University Medical Center v. Sullivan*, 973 F.2d 1065, 1081 (3rd Cir. 1992) (emphasis added). In effect, the Medicare Provider agreement is deemed an "executory contract" between the provider and the government. *Id.*, at 1076-1077.

Under the Medicare Provider agreement, a provider of Part B services such as a hospital agrees to look *exclusively* to the government (and not the patient) for payment, except for deductibles, coinsurance and copayment charges allowed under federal regulations. §1395cc(a); 42 C.F.R. §§489.30-489.32.[12]

In the case of "dual-eligibles," the contractual relationship between the government and the provider is expanded to include the state Medicaid program. In these circumstances, once the reasonable costs or charges are determined by the Secretary, a Medicare service provider is entitled to recover 100% of that amount: 80% from the Medicare program, §1395l, and 20% coinsurance from the state Medicaid program, §§1396a(a)(10)(E), 1396d(p)(3). See *Perales*, 954 F.2d at 859; *Snider*, 29 F.3d at 893. Generally, the provider may not bill the patient for any "balance" over and above the government-prescribed payment

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[12] Similarly, in the case of participating physicians, ambulance companies and suppliers, the Secretary of HHS enters into an "assignment agreement" with the provider under which the provider agrees to accept the Secretary's payment determination as *payment in full*, and is precluded from charging the Medicare enrollee more than the deductible and coinsurance based upon the approved charge determination by the Secretary. §§1395u(b)(3)(B), 1395u(h)(1).

rate. §1320a-7b(d).[13] *See* App. 43.

Thus, the essence of the contractual relationship between the petitioners' members and the government is the government's contractual responsibility for the 20% coinsurance and deductibles for medical services plaintiffs' members provided to these "dual eligible" beneficiaries. The economic burden of this debt falls in equal proportions on both the federal and state governments, since the federal government contributes 50 percent of the cost of administering the California Medicaid ("Medi-Cal") program. §1396b(a)(1), 1396d(b). With the enactment of §4714, Congress has elected to repudiate a part of that debt as part of a cost-saving measure designed to produce an estimated net federal savings of $2.1 billion over five years for the federal portion of the Medicaid program. *See*, Congressional Budget Office estimates re: Public Law 105-33. App. 48. This Court, however, has rejected the argument that Congress has the power to repudiate its own debts which constitute "property" to the debtor, simply in order to save money. *Winstar*, 135 L.Ed.2d at 1018 (Breyer, J., conc.).

Petitioner Associations do not challenge Congress' power to amend the terms of the underlying legislation on a prospective basis, for medical services not yet provided. Nonetheless, providers have a contractual right to payment of the 20 percent coinsurance at the Medicare rates for those services rendered prior to §4714's enactment, a right that vested at the time they performed such services in reliance on the payment rates established in the statute and regulations. As such, Congress cannot retroactively impair those vested rights.[14]

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[13] Emphasizing Congress' awareness of the contractual nature of the relationship between the federal government and providers, it is relevant to note that §4714(b) modifies the state Medicaid agency's cost-sharing obligations, so as to prohibit a provider from imposing any patient charge for any payment amount that is limited or reduced as a result of the new Medicaid payment – rate limitations authorized under §4714(a). §1395cc(a)(1)(A) (new).

[14] The Eighth Circuit Court of Appeals and the California courts have held that a *state* cannot constitutionally retroactively reduce Medicaid

(continued...)

In *Lynch*, which governs this case, this Court rejected on Fifth Amendment grounds Congress' attempt to legislatively retract the government's obligations on insurance contracts to save money during the Great Depression: "Congress was without power to reduce expenditures by abrogating contractual obligations. To abrogate contracts, in an attempt to lessen government expenditures, would be not the practice of economy but an act of repudiation." *Lynch, supra*, 292 U.S. at 580. See also, *Perry v. United States*, 294 U.S. 330, 350-351 (1935) (rejecting government's attempt to avoid a bond debt: "Congress is authorized to pledge the credit [of the United States] as an assurance of payment as stipulated ... To say that Congress may withdraw or ignore that pledge is to assume that the Constitution contemplates a vain promise ...); *Bowen*, 477 U.S. 55 ("Congress does not have the power to repudiate its own debts .. simply in order to save money").

More recently, in *Winstar*, a plurality of this Court held that the government could be liable for breach of contract when Congress enacted legislation abrogating previously created contractual rights of certain thrifts during the savings and loan crisis. As Justice Souter noted in quoting Justice Brandeis' observation in *Lynch*, "[p]unctilious fulfillment of contractual obligations is essential to the maintenance of the credit of public as well as private debtor." *Winstar*, 135 L.Ed.2d at 964. Justice Scalia further observed in his concurring opinion that *Lynch* and *Perry* were the two principal cases "of this century holding that the Government may not simply repudiate its obligations." *Id.* at

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(...continued)
reimbursements to health care providers. *See Minn. Ass'n of Health Care v. Minn. Dept. of P.W.*, 742 F.2d 442, 450-451 (8th Cir. 1984) (provision of new legislation which retroactively limited the rates that Medicaid nursing home providers could charge to non-qualifying residents was held to be unconstitutional impairment of contracts); *California Medical Assn. v. Lackner*, 117 Cal.App.3d 522, 566 (1981) ("any retroactive decrease in reimbursement to physicians due to the new, uniform schedules ... would be an unconstitutional 'law impairing the obligation of contract'") *See* U.S. Const. Art. I, §10.

1022 (Scalia, J., concurring). In both cases, as here, "Congress specifically set out to abrogate the essential bargain of the contracts at issue -- and in both we declared such abrogation to amount to impermissible repudiation." *Ibid.*

Retroactive application of §4714 abrogates the essential bargain of the providers' reimbursement agreements by changing their most fundamental term, the basic rate of payment. It is fundamentally unfair and constitutionally infirm for Congress to tell a provider who has been promised $100 to provide a service, that after providing the service, the rate has been changed after the fact to $80. That in effect is what Congress has attempted to do here by its purported clarification of the 1986 QMB legislation.

CONCLUSION

The Ninth Circuit's decision is totally flawed on matters of important statutory and constitutional, as well as social and economic, dimension. For the reasons discussed above, the petition for writ of certiorari should be granted and the Ninth Circuit's decision reversed.

Respectfully submitted,

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FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California non-profit public benefit corporation, d/b/a BEVERLY HOSPITAL; BELLWOOD MEDICAL CORPORATION, d/b/a BELLWOOD GENERAL HOSPITAL; CHICO COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a CHICO COMMUNITY REHABILITATION HOSPITAL, d/b/a CHICO COMMUNITY HOSPITAL; HOLLYWOOD COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS, d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD; LANCASTER HOSPITAL CORPORATION, d/b/a LANCASTER COMMUNITY HOSPITAL, et al.,

Plaintiffs-Appellees,

v.

KIMBERLY BELSHE, Director of the California Department of Health Services,

Defendant-Appellant.

No. 96-55208

D.C. No. CV-95-04053-JSL

OPINION

CALIFORNIA AMBULANCE ASSOCIATION,
Plaintiff-Appellee,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services,
Defendant,

and

KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendant-Appellant.

No. 96-56249
D.C. No.
CV-96-02322-JSL

CALIFORNIA AMBULANCE ASSOCIATION,
Plaintiff-Appellee,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services,
Defendant-Appellant.

No. 96-56485
D.C. No.
CV-96-2322-JSL

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

No. 96-56648

D.C. No. CV-03033-JSL

RICHARD GILMORE, M.D.; SARAF PROTAP, M.D.,
Plaintiffs-Appellees,
v.
DONNA E. SHALALA, Secretary of the United States Department of Health and Human Resources,
Defendant,
S. KIMBERLY BELSHE, Director of Health Services,
Defendant-Appellant.

No. 96-56699
D.C. No. CV-96-05564-JSL

RICHARD GILMORE, M.D., individually and on behalf of all those similarly situated; PRATAP SARAF, M.D., individually and on behalf of all those similarly situated,
Plaintiffs-Appellees,
v.
DONNA E. SHALALA, Ph.D., Secretary of the United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

Nos. 96-56745
97-55220
D.C. No. CV-96-05564-JSL

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services,
Defendant-Appellant.

No. 97-55022
D.C. No.
CV-96-03033-JSL

DONALD R. MACPHERSON, JR., as Successor in interest to decedent Christina MacPherson & MacPherson Oil Company Employee Welfare Benefit Plan,
Plaintiff-Appellant,

v.

EMPLOYERS HEALTH INSURANCE,
Defendant-Appellee.

No. 97-55713
D.C. No.
CV-97-00514-JSL

Appeal from the United States District Court
for the Central District of California
J. Spencer Letts, District Judge, Presiding

Argued and Submitted
October 6, 1997—Pasadena, California

Filed December 2, 1997

Before: Stephen Reinhardt and A. Wallace Tashima,
Circuit Judges, and Milton I. Shadur, District Judge.*

Opinion by Judge Shadur

SUMMARY

Health/Medicaid/MediCare and Government Assistance

The court of appeals reversed judgments of the district court. The court held that amendments to the Medicare Act in the Balanced Budget Act of 1997 allows a participating state to limit beneficiary enrollment payments under the Medicare Act's cost-sharing provision to the amount by which the state's Medicaid rate exceeds what Medicare has paid.

In § 1396a(n) of the Medicare Act, Congress dealt with persons who are eligible for both Medicare (federal health insurance program for elderly and disabled) and Medicaid (cooperative federal-state program providing matching funds to states that elect to provide medical services to needy persons). Section 1396a(n) describes what the state plans can set up to cover their obligations on behalf of qualified medical beneficiaries (QMBs).

*The Honorable Milton I. Shadur, United States District Judge for the Northern District of Illinois, sitting by designation.

Appellant Secretary of the Department Health and Human Services took the legal position that under § 1396a(n), participating states have the choice to limit their cost-sharing payments for enrollment of QMBs to the amount by which the state's Medicaid rate exceeds what Medicare has paid. This is the interpretation under which California adopted "Medi-Cal," its Medicaid plan.

In a number of federal lawsuits, appellee Beverly Community Hospital Association and other Medicare and Medicaid providers challenged the reading of § 1396a(n) given by the Secretary and appellee Director of the California Department of Health Services. In each case, the district court rejected the Secretary's interpretation that under § 1396a(n), participating states have the choice to limit their payments so that they need not pay the full cost-sharing amount.

While the cases were pending on appeal, Congress passed the Balanced Budget Act of 1997 (BBA). Included in the statute as Act 4714 is a provision that expressly amends § 1396a(n) to adopt the Secretary's position, and expressly applies to pre-enactment state payments that were the subject of litigation pending on the date of enactment. Congress captioned the new provision a "clarification" regarding state liability for Medicare cost-sharing.

The central issue on appeal was whether the BBA requires application of the Secretary's interpretation of the pre-enactment version of the Medicare statute.

[1] It did not matter whether congressional labeling of the new legislation as a "clarification" had to be credited by a court. What was significant was that Congress's characterization reflected its intention to resolve every still-live dispute in the manner specified. The statutory reference to "pending" lawsuits had to be construed as embracing cases undecided at the district court level and actions pending on appeal.

[2] Because Congress has the authority to change the law as to pending cases, its power to clarify the law—to confirm what the law has always meant—follows a fortiori. [3] If Act 4714 were to be characterized as a substantial change in the law, its retroactive application would have posed potential constitutional problems. If it merely clarified what § 1396a(n) was intended to mean, the Medicaid Act never required states to pay cost-sharing in full.

[4] Congress expressly stated as its intention that the new provision in Act 4714 was a "clarification" of the payment rules contained in § 1396a(n). Congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight.

[5] The argument, that § 4714 effected such a substantial change in terms of the government's liability to health care providers that it could not be treated as clarifying § 1396a(n), proceeded from the premise that § 1396a(n)'s meaning was clear enough so as to need no further explanation. That premise ignored the split of authority construing the statute. Clarity is absent from the Medicare and Medicaid statutes.

[6] Section 1396a(n) was particularly resistant to a single interpretation, and particularly in need of clarification. [7] Given the difficulty that courts have had in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of § 1396a(n) was worthy of real deference.

[8] Act 4714's provisions are a statement of what § 1396a(n) meant all along. That mooted all constitutional objections to the new legislation because they rested on the assertedly retroactive nature of Act 4714.

[9] Any claim that California was violating the new federal statute represented the basis for a new lawsuit. Any such claim called for the generation of a new record, against which

the trial court could determine whether there was anything to the contention that Act 4714's clarification of prior law somehow rendered invalid the Medi-Cal reimbursement methodology for hospitals. The trial court would also have to determine whether that argument might have been forfeited by not raising it the first time around.

COUNSEL

Beverly v. Belshe

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CAA v. Belshe and Shalala

Charlton G. Holland III and Ralph Johnson, California Attorney General, San Francisco, California; Alissa B. Klein, United States Department of Justice, Civil Division, Washington, D.C., for the defendants-appellants.

William J. Bush, Hanson, Bridgett, Marcus, Vlahos & Rudy, LLP, San Francisco, California, for the plaintiffs-appellees.

Gilmore v. Belshe and Shalala

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OPINION

SHADUR, District Judge:

We address here a question of first impression, not only in this Circuit but (understandably in light of the recency of the legislation involved) in any court: whether a congressional enactment adopted in August 1997, but stating that it is retroactive and applicable to pending cases, calls for approval of the reading that has been given to the pre-enactment version of the same legislation by the Secretary of the United States Department of Health and Human Services ("Secretary"). Because we answer that question in the affirmative, we reverse all three decisions below.[1]

All three of these sets of appeals pose a common problem: whether the State of California may choose to limit certain payments, as required by statute to be made to enroll poor people—qualified Medicare beneficiaries ("QMBs")—in the Medicare insurance program, to the amount by which California's Medicaid rate exceeds what Medicare has paid. Those payments, required from all participating states under the Medicaid Act, extend to deductibles, coinsurance and copayments that the QMBs cannot bear fully and that the State is

[1]In each instance the jurisdiction of the district court was based upon 28 U.S.C. §1331. All three judgments are appealable pursuant to 28 U.S.C. §1291.

required to pay on their behalf (whether totally or in part is at stake in these cases).

Title XVIII of the Social Security Act (the "Medicare Act," 42 U.S.C. §§1395-1395ccc[2]) provides a federal health insurance program for elderly and disabled persons. Medicare Part A covers inpatient hospital services and certain related benefits (Sections 1395c-1395i-4), and it is provided automatically for individuals entitled to Social Security retirement or disability benefits (Section 426). Medicare Part B is a voluntary program under which Medicare-eligible persons can obtain supplemental insurance for various outpatient services from physicians and other providers (Sections 1395j-1395w-4). It is financed by a combination of federal funds and premiums paid by or on behalf of eligible individuals (Sections 1395r, 1395t(g)). Both Medicare Part A and Medicare Part B call for payments by covered individuals that constitute the deductibles, coinsurance and copayments referred to earlier.

Title XIX of the Social Security Act (the "Medicaid Act," Sections 1396-1396v) is a cooperative federal-state program that provides federal matching funds to states that elect to provide medical services to certain needy individuals (see Section 1396; *Harris v. McRae*, 448 U.S. 297, 301 (1980)). Although states are not required to participate in Medicaid, if they elect to do so they must follow federal guidelines (*Harris*, 448 U.S. at 301) and must submit for Secretary's approval their state plans that describe the states' intended means for insuring compliance with those guidelines (Section 1396a(b)).

What is at issue in these three sets of appeals is the area of overlap between the Medicare and Medicaid Acts where coverage for the elderly poor is involved. Those persons are often

[2]All further citations to Title 42 provisions will take the form "Section —," utilizing the Title 42 numbering system rather than the internal numbering of the Acts involved.

entitled to participate in such coverage but may not be able to afford to pay the required deductible and coinsurance amounts under Medicare Part A or the premiums and payments needed to enroll in Medicare Part B. At the time that the various lawsuits were filed below, Congress had dealt with individuals who are eligible for both Medicare and Medicaid (see Section 1396d(p)(1)) by stating in Section 1396a(n) of the Medicaid Act what the state plans could set up to cover their obligations on behalf of the QMBs involved.

Three types of plaintiffs (now appellees) are involved in these appeals. *Beverly Hospital* is a class action on behalf of all California hospitals that provide inpatient hospital services under the Medicare and Medicaid Acts. *California Ambulance* involves two types of associations, California Ambulance Association and physician associations including California Medical Association, each type of association also representing providers of services under the two statutes. And *Gilmore* was brought by two doctors who provide outpatient physician services to persons under the two statutes.[3] Thus *Beverly Hospital* involves Medicare Part A, while *California Ambulance* and *Gilmore* implicate Medicare Part B.

Secretary is an appellant in all of the cases except for *Beverly Hospital*, in which she was given leave to participate as an amicus curiae. Director S. Kimberly Belshe of the California Department of Health Services ("Director") is an appellant in all of the cases. Both appellants subscribe to Secretary's legal position pursuant to which California adopted its Medicaid state plan ("Medi-Cal"), which position asserts that under Section 1396a(n) participating States such as California have the choice to limit their payments as described earlier, so that they need not pay the *full* cost-

[3]Although the *Gilmore* case was originally intended to be a class action, any need for class certification was obviated when defendants agreed that the result in the case would be followed as to all persons providing such services.

sharing amount. In each of the cases before us the District Court rejected that contention, as have all four Courts of Appeals that have addressed the question: *Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994)("*Kozlowski*"); *Haynes Ambulance Serv., Inc. v. State of Alabama*, 36 F.3d 1074 (11th Cir. 1994)("*Haynes*"); *Pennsylvania Med. Soc'y v. Snider*, 29 F.3d 886 (3d Cir. 1994)("*Snider*"); and *New York City Health and Hosps. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992)("*Perales*").[4]

After the scheduled briefing of these appeals had been completed, Congress entered the picture. Its Balanced Budget Act of 1997 ("Act"), signed into law by the President on August 5 of this year, included as Act §4714 a provision that expressly amends Section 1396a(n) to adopt the position advanced by Secretary and Director here:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.
>
> (3) In the case in which a State's payment for

[4]Although this does not affect our resolution of these cases in light of what follows, it is worth noting that those four Courts of Appeals have employed divergent approaches (reading the statute differently) in reaching their conclusions. And it may be added that those four decisions (and the decisions now on appeal) do not at all reflect a unanimous judicial reaction: For example, two recent District Court decisions, *Dameron Physicians Med. Group v. Shalala*, 961 F.Supp. 1326 (N.D. Cal. 1997) and *Kulkarni v. Leean*, No. 96 C 884-S, 1997 WL 527674 (W.D. Wis. June 23), have joined other lower court decisions going the other way. See also the discussion of the problem at 66 U.S.L.W. 2233 (Oct. 21, 1997).

> medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—
>
> > (A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;
> >
> > (B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and
> >
> > (C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.
>
> This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

There is no dispute among the litigants that if this new statutory provision (which Congress has captioned "Clarification Regarding State Liability for Medicare Cost-Sharing") is applicable, it requires the reversal of the District Court's decisions. One minor variant exists: Beverly Hospital contends that a remand is necessary because Secretary's methodology,

as applied to that hospital's situation, does not mesh with the new enactment. We speak briefly to that question later.

Because Congress was deliberately targeting what were known to be existing disputes on this subject, Act §4714(c) went on to prescribe a retroactive effective date of the quoted amendment:

> (c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act[6] and that is pending as of, or is initiated after, the date of the enactment of this Act.

That being the case, the relevant considerations in our three cases have shifted from those that had occupied the parties' entire scheduled briefing, which (as stated earlier) had been completed before the congressional enactment. We therefore invited and received supplemental briefing on the effect of Act §4714 on these cases. And having done so, we eschew any analysis of those original arguments and turn instead to the validity and applicability of the August 1997 enactment.

Standard of Review

Both because constitutional questions are at issue and

[6]Those cited sections of the Social Security Act respectively correspond to Sections 1396a(n) and 1396(d) in the Title 42 usage employed in this opinion. Those sections are in fact the statutory provisions involved in these appeals.

because the cases come up on summary judgment, we engage in a de novo review of the district courts' final judgments (*Gray v. First Winthrop Corp.*, 989 F.2d 1564, 1567 (9th Cir. 1993) ("The constitutionality of a statute is a question of law which we review de novo"); *Brinson v. Linda Rose Joint Venture*, 53 F.3d 1044, 1047 (9th Cir. 1995) (holding that an order granting summary judgment is reviewed de novo)). Each of the issues before us will be examined through that lens.

Application of Act §4714

[1] At the outset we examine the coverage of these appeals by the new legislation—a matter that was challenged in the appellees' briefs but was not addressed by their counsel during oral argument. As the earlier-quoted Act §4714(c) states, the new amendments apply to any payments by a State for items and services furnished pre-enactment as long as the payment "is the subject of a lawsuit...that is pending as of... the date of the enactment of this Act." In that respect it does not matter whether the congressional labeling of the new legislation as simply a "clarification" has to be credited by a court (a subject that we deal with in a moment). What is instead significant is that Congress' characterization plainly reflects its intention to resolve every still-live dispute in the manner specified by the new legislation. Hence the statutory reference to "pending" lawsuits must be construed as embracing not only undecided cases at the District Court level but also actions pending on appeal, such as the ones before us.

[2] We have previously ascribed precisely that meaning to the term "pending" in *Gray*, 989 F.2d at 1571. There we cited and quoted from numerous earlier decisions upholding Congress' power to impact the results in cases still "pending" on appeal without running afoul of separation of powers principles:

> These cases are properly construed as "pending" cases for separation of powers purposes. *See Griffith*

> *v. Kentucky*, 479 U.S. 314, 321 n.6, 107 S.Ct. 708, 712 n.6, 93 L.Ed.2d 649 (1987)(judgment is "final" and case is no longer pending only after "the availability of appeal [is] exhausted, and the time for a petition for certiorari [has] elapsed or a petition for certiorari finally [has been] denied"); *see also Georgia Ass'n of Retarded Citizens v. McDaniel*, 855 F.2d 805, 813 (11th Cir. 1988)("When it so intends, [Congress'] ability to affect the content of a nonfinal judgment in a civil case, through retroactive legislation ceases only when a case's journey through the courts comes to an end."), *cert. denied*, 490 U.S. 1090, 109 S.Ct. 2431, 104 L.Ed.2d 988 (1989); *de Rodulfa v. United States*, 461 F.2d 1240, 1253 (D.C. Cir.)("[T]he suit is pending until the appeal is disposed of, and until disposition any judgment appealed from it is still *sub judice*.") (internal quotations omitted), *cert. denied*, 409 U.S. 949, 93 S.Ct. 270, 34 L.Ed.2d 220 (1972).

And what *Gray*, *id.* then said, albeit in the different context of a change in a statute of limitations, applies with equal force to give identical content to the word "pending" in Act §4714(c):

> Because none of the cases here have completed their journey through the appellate process, Congress has the authority to change the underlying substantive law by altering the statute of limitations in a way that affects those pending cases.

Because Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori.

[3] That being the case, the next line of inquiry is whether the new enactment is valid in its application to such pending cases. On that score a key threshold issue is whether the

enactment was truly a "clarification" of the prior statute (as Congress said), or was instead a substantial change in the law. If Act §4714 were to be characterized in the latter fashion, its retroactive application would pose a series of potential constitutional problems. If however Act §4714 merely clarifies what Section 1396a(n) was originally intended to mean, then the Medicaid Act never required states such as California to pay cost-sharing in full. In that event the only function of Act §4714 in this situation is to state more clearly what the law already was—it has no retroactive effect that might be called into constitutional question. Because appellees do not dispute the constitutionality of the prospective application of Act §4714, if that provision merely clarifies Section 1396a(n) there are also no potential constitutional problems with the application of the enactment to these pre-Act cases.

[4] As already indicated, Congress expressly (and formally) stated as its intention that the new provision in Act §4714 was a "clarification" of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic (as demonstrated by *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 380-81 & n.8 (1969) and earlier cases cited there) that congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight (see most recently *Loving v. United States*, 116 S. Ct. 1737, 1749 (1996), quoting the *Red Lion* language as earlier repeated in *Consumer Product Safety Comm'n v. GTE Sylvania*, 447 U.S. 102, 118 n.13 (1980); and see also the plurality opinion in *United States v. Winstar Corp.*, 116 U.S. 2432, 2463 (1996)(speaking in terms of "significant weight")).

Other cases that question the competence of a later Congress to opine on the intended meaning of an earlier statute are readily distinguishable. All of those cases have involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments (*United States v. South-*

western Cable Co., 392 U.S. 157, 170 (1967), rejecting the use of congressional opinions contained solely in House Committee Reports; *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979), rejecting the use of congressional opinions expressed only in Senate Report; and see *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 839-40 (1988), rejecting the use not only of a later House Committee Report but also of the later enactment as such as bases for inferring the intent of an earlier Congress). By contrast, here Congress has formally declared Act §4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports.[6] Such formal legislative action squarely fits the *Red Lion* mold as so often (and so recently) reconfirmed by later cases, so that Act §4714 is entitled to great weight in construing the meaning of Section 1396a(n).

[5] Appellees contend that Act §4714 effected such a substantial change in federal law in terms of the government's liability to health care providers that it cannot be treated as simply clarifying Section 1396a(n). But that argument proceeds from the premise that Section 1396a(n)'s meaning was clear enough so as to need no further explanation. Not only does that premise ignore the split of authority construing the statute (though to be sure the four Court of Appeals opinions have uniformly rejected Secretary's reading), but even more significantly any quality of crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes (thus even one of the cases relied on by appellees, *Kozlowski*, 42 F.3d at 1450, has pungently—and accurately—characterized the provisions detailing Medicaid and Medicare

[6]While titles of acts are not part of the law, they can be used to resolve ambiguity in a statute, so long as they do not contradict the actual text (see, e.g., *INS v. National Ctr. for Immigrants' Rights, Inc.*, 502 U.S. 183, 189 (1991) and cases cited there). In this instance the congressional title, rather than merely resolving an ambiguity, parallels the provision in Act §4714(c) that specifically makes the statute applicable to pre-Act services involved in pending litigation.

financing as "among the most completely impenetrable texts within human experience").

[6] Section 1396a(n) is a superb example of the baffling nature of the statute. It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification. While one battle has raged (with mixed results) over whether to accept Secretary's construction of the provision, even the courts that have rejected Secretary's approach have not expressed a single construction of the statute (compare *Kozlowski*, 42 F.3d at 1454, reading Section 1396a(n) to allow a state to exercise the option to pay more for a QMB than for a dual-eligible person; *Perales*, 954 F.2d at 859, stating "it appears that the reason that section a(n) authorizes payment beyond the Medicare amount, when it is required by another section, is to clarify that the Medicaid Act does not prohibit a provider from accepting more than the Medicaid rate"; and *Snider*, 29 F.3d at 895, holding that Section 1396a(n) "authorizes the states to deviate from their schedules or payment methods with respect to QMB Part B cost-sharing payments, thus carving out an exception to the general requirement to comply with the Medicaid fee schedules or payment methods"). Only *Haynes*, 36 F.3d at 1076, by following the interpretation established in *Snider*, avoids the spectre of four Courts of Appeals reaching the same result for four (rather than three) different reasons. Congress noted the existing confusion when it made the statement (really an understatement) that the amount that states were required to pay on behalf of QMBs was "the subject of some controversy" (H. Conf. Rep. No. 105-217, 143 Cong. Rec. H6252 (daily ed. July 29, 1997)).

[7] Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference. Appellees' arguments that Act §4714 is new law, despite Congress' unambiguous title for that section, cannot

override that deference, because those arguments incorrectly presume a clearly established meaning for Section 1396a(n)—something that simply did not exist before Act §4714 was adopted.

[8] We therefore honor Congress' "clarification" label and accept Act §4714's provisions as a statement of what Section 1396a(n) has meant all along. That moots all of appellees' constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of Act §4714. But it is worth adding that we have, en route to our decision, carefully explored the litigants' arguments both as to the pre-Act version of Section 1396a(n) and as to the constitutional issues raised by appellees if Act §4714 were to be viewed as a retroactive change in, rather than a declaratory clarification of, the prior law—questions implicating the separation of powers, the Contract Clause and the Due Process Clause. And that exploration, which necessitated an effort on our part to parse the intricate and complex provisions of the pre-Act legislation, has only deepened our conviction that Congress' stated intention of clarifying that pre-existing law should be credited.

That leaves only one tag end for discussion, a statutory claim raised by the plaintiff Association in No. 96-55208 ("Beverly") that is unique to it as a provider of inpatient medical services to QMBs under Medicare Part A. Beverly argues in its supplemental brief that Medi-Cal's methodology for reimbursing hospitals for their Medicare expenses under Part A is not legal under either Beverly's or Secretary's interpretation of Act §4714(a)(2). Beverly urges this Court to affirm the district court's ruling below on that ground (under the familiar principle, as repeated in *Herrig v. FDIC*, 82 F.3d 282, 284 (9th Cir. 1996), that an appellate court may uphold a ruling on any basis that the record supports, even if it was not considered by the lower court).

But before an appellate court will consider such an issue, ordinarily the argument must have been raised sufficiently for

the trial court to rule on it (*A-1 Ambulance Serv. v. County of Monterey*, 90 F.3d 333, 338 (9th Cir. 1996), citing *In re E.R. Fegert Inc.*, 887 F.2d 955, 957 (9th Cir. 1989)). In this instance Beverly initially cited a single excerpt from the trial court record that it said had raised the statutory issue about Medi-Cal's Medicare Part A reimbursement policies. But post-argument its counsel has clarified its position as presenting a different assertion: that its current argument could not have been made below because it arose only as a result of standards set forth in the later-enacted Section 4714(a)(1), now codified as Section 1396a(n)(2).

[9] We need not resolve that newly-raised contention, nor does it call for a remand rather than a reversal. Any claim that California is violating the new federal statute—something that is necessarily not encompassed within the scope of the record as it was presented to the trial court and is thus not on review in the appeal before us—really represents the basis for a new lawsuit. Any such claim would call for the generation of a new record, against which a trial court could determine in the first instance whether there is anything to the contention that Act §4714's clarification of the prior law somehow renders the Medi-Cal reimbursement methodology for hospitals under Medicare Part A invalid. And in that respect the trial court would also have to determine whether despite the existence of the new enactment, Beverly's argument on that score is one that it could perhaps have raised the first time around, so that it might be held to have forfeited the argument by virtue of its not having done so in this original litigation.

Conclusion

For the reasons that we have stated here at some length, we conclude that Act §4714 is a clarification of the original intent of Congress when it passed Section 1396a(n). That being the case, the district courts' orders granting summary judgment in favor of each appellee are REVERSED. As a final point, we note that Director Belshe has not requested a remand in order

to seek to recoup any excessive payments made pursuant to the district court's orders. We indicate no view as to her right to obtain any such relief.

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED

MAR - 3 1998

Cathy A. Catterson, Clerk

U.S. Court of Appeals

BEVERLY COMMUNITY HOSPITAL ASS'N,	)	No 96-55208
Plaintiff-Appellee,	)	D.C. No. CV-95-4053 JSL
v.	)	**ORDER**
S. KIMBERLY BELSHE, Director of the California Dep't of Human Services,	)	
Defendant-Appellant.	)	
CALIFORNIA AMBULANCE ASS'N, CALIFORNIA MEDICAL ASS'N, et al.,	)	Nos. 96-56249 96-56485 96-56648 97-55022
Plaintiffs-Appellees,	)	
v.	)	D.C. Nos. CV-96-2322-JSL CV-96-3033-JSL
S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services,	)	
Defendants-Appellants.	)	

RICHARD GILMORE, et al.,	)	Nos. 96-56699
Plaintiffs-Appellees,	)	96-56745
	)	97-55713
v.	)	97-55220
	)	
S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services,	)	D.C. Nos. CV-96-5564-JSL
Defendants-Appellants.	)	

Before: REINHARDT and TASHIMA, Circuit Judges, and SHADUR, District Judge.**

The panel has voted to deny the petitioner for rehearing and to reject the suggestions for rehearing en banc. The full court has been advised of the suggestion for rehearing en banc, and no judge of the court has requested a vote on the suggestions for rehearing en banc. Fed. R. App. P. 35(b).

The petitions for rehearing are denied and the suggestions for rehearing en banc are rejected.

** The Honorable Milton I. Shadur, Senior United States District Judge for the Northern District of Illinois, sitting by designation.

ENTERED
CLERK, U.S. DISTRICT COURT

JUL 25, 1996

Central District of California
By _____ Deputy

FILED
CLERK, U.S. DISTRICT COURT

JUL 23, 1996

Central District of California
By _____ Deputy

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

CALIFORNIA AMBULANCE ASSOCIATION, Plaintiff, v. DONNA SHALALA, ET AL., Defendants	CV96-2322 JSL JUDGMENT

The motion of plaintiff California Ambulance Association for summary judgment came for hearing regularly on July 22, 1996. Having reviewed the papers filed in connection with this matter, having heard oral argument, and being fully apprised of the relevant facts and law, IT IS HEREBY ORDERED, ADJUDGED AND DECREED as follows:

(1) The motion for summary judgment of plaintiff California Ambulance Association is GRANTED;

(2) Under the federal Medicare and Medicaid Acts, including, but not limited to, 42 U.S.C. §§1396a(a)(10)(E), 1395(d)(p)(1) and 1396d(p)(3), plaintiff's members who provide

medical services to qualified medicare beneficiaries are entitled to compensation for such services at 80% of the allowable medical rate plus full Medicare cost-sharing amounts;

(3) That the amount of such cost-sharing is not limited by the Medi-Cal reimbursement rate for such services;

(4) Section 14109.5 of the California Welfare & Institutions Code and implementing bulletins or regulations insofar as they purport to limit the payment of Medicare cost-sharing for Part B services to QMBs to the Medi-Cal reimbursement rate, violate the Medicare and Medicaid Acts including, without limitation, 42 U.S.C. §1396(a)(10)(E) and the rights of plaintiff and its members under 42 U.S.C. §1983;

(5) That the California Medicaid State Plan and Section 3490.14 of the State Medicaid Manual are invalid to the extent that they purport to limit payment of Medicare cost-sharing for Part B services to QMBs only to the extent that such cost-sharing plus the 80% Medicare payment does not exceed the Medi-Cal reimbursement rate.

(6) Plaintiff is entitled to injunctive relief restraining S. Kimberly Belshe from continuing to execute and implement California Medi-Cal programs to the extent that said program limits the payment of the services of plaintiff's members to QMBs to a sum that does not exceed the Medi-Cal reimbursement rate, said injunctive relief will be effective as of July 23, 1996.

(7) Plaintiffs are entitled to their attorneys' fees and costs under 42 U.S.C. §1988.

While the Court considered independently all of the issues

presented in this case, it adopts the comprehensive analysis of these very same arguments in New York City Health and Hospital Corp. v. Perales, 54 F.2d 854 (2nd Cir. 1992), Pennsylvania Medical Society v. Snider, 29 F.3d 866 (3rd Cir. 1994), and Haynes Ambulance Service v. Alabama, 36 F.3d 1074 (11 Cir. 1994). It also adopts the similar reasoning in Rehabilitation Association of Virginia v. Kozlowski, 42 F.3d 144 (4th Cir. 1994), except for that court's construction of the phrase "eligible individuals who are not qualified medicare beneficiaries" in §42 U.S.C. 1396 (n), an issue which the Court find unnecessary to determine in order to reach its decision. The Court, in the present case and in Beverly Community Hospital Association v. Belshe, CV95-4053 (C.D.Cal. Dec. 18, 1995), finds itself in accord with the four Circuits in determining that the government's statutory construction would render the provisions of the Medicare and Medicaid internally inconsistent and undermine the Congressional purposes of the provisions in question.

IT IS SO ORDERED.

Dated:_____

/s/
J. Spencer Letts
United States District Judge

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Attorneys for Plaintiffs

FILED
CLERK, U.S. DISTRICT COURT
SEP 16, 1996
Central District of California
By_____ Deputy

ENTERED
CLERK, U.S. DISTRICT COURT
SEP 18, 1996
Central District of California
By_____ Deputy

LODGED
CLERK, U.S. DISTRICT COURT
AUG 16, 1996
Central District of California
By_____ Deputy

IN THE UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

CALIFORNIA MEDICAL ASSOCIATION, et al,	No. CV96 3033 JSL (JRx)
Plaintiffs,	~~[PROPOSED]~~ ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT
vs.	
DONNA SHALALA, Secretary of United States Department of Health,	
Defendants.	

The motion of plaintiffs California Medical Association, California Academy of Family Physicians, California Society of Anesthesiologists, California Urological Association, California Chapter of the American College of Emergency Physicians,

California Chapter of the American College of Cardiology, California Society of Internal Medicine, California Society of Physician Medicine and Rehabilitation, California Radiology Society, and Chapter of the American College of Radiology, for partial summary judgment came on regularly before the above-entitled court on July 22, 1996. Hanson, Bridgett, Marcus, Vlahos & Rudy by William J. Bush appeared on behalf of plaintiff California Medical Association. California Attorney General by Charlton G. Holland, III appeared on behalf of defendant S. Kimberly Belshe as Director of the California Department of Health Services. The United States Attorney by Russell W. Chittenden appeared on behalf of defendant Donna Shalala, as Secretary of United States Department of Health and Human Services.

The Court having read and considered plaintiffs' moving papers and defendants' opposition thereto, and on the basis of the uncontroverted facts presented in support of said motion and good cause appear therefor,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED as follows:

1. Plaintiffs' motion for summary judgment is granted.

2. Under the federal Medicare and Medicaid Acts including, but not limited to, 42 U.S.C.§§1396a(a)(10)(E), 1394(d)(p)(1) and 1396d(p)(3), plaintiffs' members who provide physician services to qualified medicare beneficiaries are entitled to compensation for such services at 80% of the allowable medical rate plus full Medicare cost-sharing amounts.

3. That the amount of such full cost-sharing is not limited by the Medi-Cal reimbursement rate for such services.

4. Section 14109.5 of the California Welfare & Institutions Code and implementing bulletins or regulations insofar as they purport to limit the payment of Medicare cost-sharing for Part B services to QMBs to the Medi-Cal reimbursement rate, violate the Medicare and Medicaid Acts including, without limitation, 42 U.S.C. §1396a(a)(10)(E) and the rights of plaintiffs and their members under 42 U.S.C. §1983.

5. That the California Medicaid State Plan and Section 3490.14 of the State Medicaid Manual are invalid to the extent that they purport to limit payment of Medicare cost-sharing for Part B services to QMBs only to the extent that such cost-sharing plus the 80% Medicare payment does not exceed the Medi-Cal reimbursement rate.

6. Plaintiffs are entitled to injunctive relief restraining defendant S. Kimberly Belshe from continuing to execute and implement California Medi-Cal programs to the extent that said program limits the payment of the services of plaintiff's members to QMBs to a sum that does not exceed the Medi-Cal reimbursement rate, said injunctive relief will be effective as of September 9, 1996.

7. Plaintiffs are entitled to their attorneys' fees and costs under 42 U.S.C. §1988.

Dated: September 16, 1996.

/s/ J. Spencer Letts
Judge of the U.S. District Court

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

I. UNITED STATES CONSTITUTION

II. Article I, §10

No State shall . . . pass any . . . Law impairing the Obligation of Contracts . . . .

III. Article III

Section 1. The judicial power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. . . .

Section 2. The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or which shall be made, under their Authority . . . .

IV. Fifth Amendment

No person shall . . . be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

STATUTES

Title 42 U.S.C. §1396a(a)(10)(E)(i)

A State plan for medical assistance must . . .

(10) provide—

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title; . . . except that . . . (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section and section 1396o(b).

Title 42 U.S.C. §1396a(a)(15) [repealed Pub.L. 100-360, Title III, §301(e)(2)(c) as added by Pub.L. 100-485, Title VI, §608(d)(14)(I)(iii), Oct. 13, 1988, 102 Stat. 2416]

STATE PLANS FOR MEDICAL ASSISTANCE

§1396a(a) A State plan for medical assistance must—

. . .

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by title XVIII, provide—

(A) for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such title; and

(B) where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to any such individual under the insurance program established by part B of such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources.

Title 42 §1396a(n) Payment Amounts [Pre-1997 Balanced Budget Act]

(n) In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

Title 42 U.S.C. §1396d(p) [Pre-1997 Balanced Budget Act]

Qualified medicare beneficiary; medicare cost sharing

(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395I-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395I-2a of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

. . .

(3) The term "medicare cost-sharing" means the following cost incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395I-2 or 1395I-2a of this title; and

(ii) premiums under section 1395r of this title.

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395l(b) of this title).

(D) The difference between the amount that is paid under section 1395l(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent."

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

Balanced Budget Act Of 1997

Sec. 4714. Medicaid Payment Rates for Certain Medicare Cost-Sharing

(a) Clarification Regarding State Liability for Medicare Cost-Sharing

(1) In General. Section 1902(n) (42 U.S.C. 1396a(n)) is amended—

(A) by inserting "(1)" after "(n)", and

(B) by adding at the end the following:

"(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

"(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual."

(2) Conforming Clarification. Section 1905(p)(3) (42 U.S.C. §1396d(p)(3)) is amended by inserting "(subject to section 1902(n)(2))" after "means."

(b) Limitation on Medicare Providers

(1) Provider Agreements. Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the comma at the end the following: ", and (ii) not to impose any charge that is prohibited under section 1902(n)(3)."

(2) Nonparticipating Providers. Section 1848(g)(3)(A) (42 U.S.C. 1395w-4(g)(3)(A)) is amended by inserting before the period at the end the following: "and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section."

(c) Effective Date. The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act.

California Welfare & Institutions Code §14109

Determination of medical needs; inclusion of cost of deductibles or cost sharing charge

In determining the needs of any person eligible under this chapter, and the amount of health care such person is entitled to receive, the department shall include the cost of any deductibles or, cost sharing or similar charge imposed in connection with benefits to which such person may be entitled under the federal program of health insurance for the aged and disabled, except that for those individuals 65 years of age of over, who prior to July 1, 1973, were ineligible under the federal program of health insurance for the aged, the director may include such costs.

V. California Welfare & Institutions Code §14109.5

Limitation on reimbursement rate notwithstanding inclusion of cost of deductibles or cost sharing charge; change orders; expeditious implementation

Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this

chapter. For purposes of this section, effective October 1, 1992, the reimbursement rates estab-lished under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services.

The fiscal intermediary shall expedite the implementation of any change order resulting only from this section. The department shall provide sufficient funding for any such change order to enable the fiscal intermediary to implement such change order expeditiously and to not have to divert staff or other resources from existing contract tasks, including but not limited to those resources dedicated to the implementation of all other change orders.

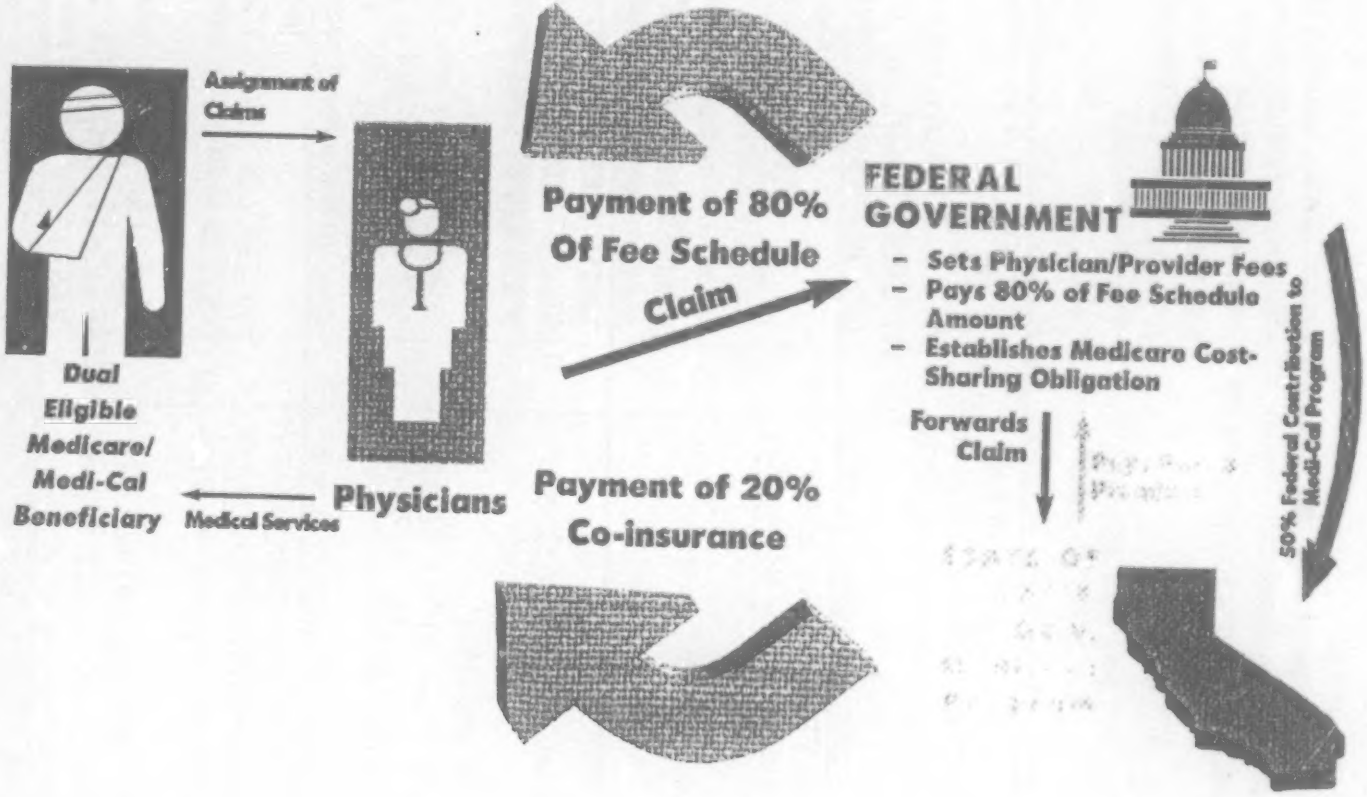
RETROACTIVE PROVISIONS AND CLARIFYING PROVISIONS CONTAINED WITHIN THE BALANCED BUDGET ACT OF 1997

CLARIFICATION OR RETROACTIVE PROVISION	CONFERENCE REPORT CITATION
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4331, 111 Stat. 395, 395-96 (1997). Amends: 42 U.S.C. §§1320a-7d(b)(2)(D); 1320a-7e(g)(3)(C); 1320a-7e(g)(5); 1320a-7(a)-(b); 1320a-7e(b); and 1320a-7a(i)(6).	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 345 (stating that the amendments contained in subsections (a), (b), (d), and (e) would be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4632, 111 Stat. 486 (1997). Amends: 42 U.S.C. §1395y(b)(2)(B).	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 452 (declaring that clarification was necessary due to 1994 court decisions, which held that HCFA could not ignore insurance plan filing limits when seeking recovery for overpayments from such plans).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4714, 111 Stat. 509, 509-10 (1997). Amends: 42 U.S.C. §1396a(n).	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 491 (stating that clarification was necessary due to court decisions that forced state Medicaid programs to reimburse Medicare providers at full Medicare rates for certain services).

CLARIFICATION OR RETROACTIVE PROVISION	CONFERENCE REPORT CITATION
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4722, 111 Stat. 514, 514-15 (1997). Amends: 42 U.S.C. §§1396b(w)(3); 1396b(b).	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 496 (declaring that the amendments apply to taxes imposed before, on, or after the date of the Act's enactment).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §4757, 111 Stat. 527 (1997). Amends: 42 U.S.C. §1315.	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 516 (declaring that the amendments apply to demonstration projects initially approved before, on, or after the date of the Act's enactment).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5001(h), 111 Stat. 577, 593 (1997). Amends: 42 U.S.C. §608.	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5002, 111 Stat. 593, 593-94 (1997). Amends: 42 U.S.C. §604(d).	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5003, 111 Stat. 594 (1997). Amends: 42 U.S.C. §607(c)(2)(D).	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5004, 111 Stat. 594 (1997). Amends: 42 U.S.C. §609(a).	

CLARIFICATION OR RETROACTIVE PROVISION	CONFERENCE REPORT CITATION
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5301-5308, 111 Stat. 597, 597-603 (1997). Amends: 8 U.S.C. §§1612(a)(2); 1612(a)(2)(D)(i); 1612(a)(2)(A); 1612(b)(2); 1612(b)(2)(A); 1613; 1613(b)(1); 1622(b)(1); and 1641(b).	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5401, 111 Stat. 603 (1997). Amends: 42 U.S.C. §503.	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 570 (stating that this provision was promulgated in response to a federal court decision and that the language applies to any period beginning before, on, or after the date of the Act's enactment).
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5501-5518, 111 Stat. 606, 606-621 (1997). Amends: Portions of 42 U.S.C. §§602; 603; 604; 607; 608; 609; 611; 612; 613; 652; and 1308.	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5525, 5528, 111 Stat. 624, 624-25 (1997). Amends: Section 105(b)(5) of the Contract with America Advancement Act of 1996, Pub. L. No. 104-121, 110 Stat. 853.	H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess. (1997), *reprinted in* 1997 U.S.C.C.A.N. 575 (stating that this amendment was necessary because at least one court reached conclusions regarding the provisions' meaning that were contrary to Congressional intent).

CLARIFICATION OR RETROACTIVE PROVISION	CONFERENCE REPORT CITATION
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5531-5557, 111 Stat. 625, 625-38 (1997). Amends: Portions of 42 U.S.C. §§608, 653, 654, 657, 663, 664, and 666.	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §§5561-5574, 5582, 111 Stat. 638, 638-43 (1997). Amends: Portions of 8 U.S.C. §§1611-1613; 1621; 1622; 1631; 1641-1645; 42 U.S.C. §1383.	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §5612, 111 Stat. 647 (1997). Amends:29 U.S.C. §1169(a)(2)(B).	
Balanced Budget Act of 1997, Pub. L. No. 105-33, §8033, 111 Stat. 669 (1997). Amends: 38 U.S.C. §3726.	


Assignment of Claims
Payment of 80% Of Fee Schedule Claim
FEDERAL GOVERNMENT
- Sets Physician/Provider Fees
- Pays 80% of Fee Schedule Amount
- Establishes Medicare Cost-Sharing Obligation
Forwards Claim
50% Federal Contribution to Medi-Cal Program
Dual Eligible Medicare/ Medi-Cal Beneficiary
Medical Services
Physicians
Payment of 20% Co-insurance

[LOGO]

June E. O'Neill
Director

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
Washington, D.C. 20515

August 12, 1997

Honorable Franklin D. Raines
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Raines:

The Congressional Budget Office, after consulting with the Committees on the Budget of the House of Representatives and the Senate, provides the enclosed estimated of the effects of H.R. 2014 (Public Law 105-34), the Taxpayer Relief Act of 1997, and H.R. 2015 (Public Law 105-33), the Balanced Budget Act of 1997, on direct spending and receipts. These estimates are required by section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. H.R. 2014 and H.R. 2015 were cleared by the Congress on July 31 and signed by the President on August 5. Section 10213 of H.R. 2015 provides that these two laws are not counted for pay-as-you-go purposes.

On August 11 the President identified one provision of Public Law 105-33 and two provisions of Public Law 105-34 for cancellation under the terms of the Line Item Veto Act. CBO's estimates do not reflect the effects of the proposed cancellations.

Sincerely,

/s/ June E. O'Neill
JUNE E. O'NEILL

Enclosures

cc: Honorable John R. Kasich
Chairman, House Committee on the Budget

Honorable John M. Spratt, Jr.
Ranking Minority Member, House Committee on the Budget

Honorable Pete V. Domenici
Chairman, Senate Committee on the Budget

Honorable Frank R. Lautenberg
Ranking Minority Member, Senate Committee on the Budget

Honorable Bill Archer
Chairman, House Committee on Ways and Means

Honorable Charles B. Rangel
Ranking Minority Member, House Committee on Ways and Means

Honorable William V. Roth, Jr.
Chairman, Senate Committee on Finance

Honorable Daniel Patrick Moynihan
Ranking Minority Member, Senate Committee on Finance

BUDGETARY IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1997

SUMMARY AND INTRODUCTION

As part of a plan to balance the federal budget by 2002, the 105th Congress enacted and President Clinton signed two major pieces of legislation: the Taxpayer Relief Act of 1997 (H.R. 2014/Public Law 105-34) and the Balanced Budget Act of 1997 (H.R. 2015/Public Law 105-33). The Balanced Budget Act achieves $127 billion in net deficit reduction over the 1998-2002 period. Gross savings of $160 billion comprise:

- $112 billion from slowing the growth of the Medicare program;
- $21 billion from auctioning licenses to use portions of the electromagnetic spectrum;
- $7 billion from changes to Medicaid;
- $5 billion from increasing excise taxes on cigarettes and other tobacco products; and
- $15 billion from other spending reductions and tax increases.

These savings are partly offset by additional spending of $33 billion:

- $20 billion for children's health insurance initiatives and
- $13 billion to mitigate the effects of last year's welfare reform law.

The act also extends the limits on discretionary spending and the pay-as-you-go procedures for direct spending and receipts, but these provisions do not directly alter federal outlays or revenues. The summary table provides estimates of the act's budgetary

effects by title. The following pages give details by program and provision.

Table 4D.—Estimated Budgetary Impact of Subtitle H, Medicaid
(By fiscal year, in billions of dollars)

Medicaid rates for Medicare cost sharing for QMB and duly eligible beneficiaries:

By Fiscal year, in billions of dollars	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2002 Total	1998-2007 Total
Medicaid	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.7	-1.8	-5.0	-12.6
Medicare Benefits	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.9	1.0	1.0	2.9	7.3

SOURCE: Congressional Budget Office

* * * *

Medicaid Rates as Payment in Full. In recent years, many states have been required by court decisions to pay full Medicare rates for cost sharing for QMBs and people dually eligible for Medicare and Medicaid. This provision overturns these decisions and gives states the option not to pay providers Medicare cost sharing amounts in excess of Medicaid rates. According to the Physician Payment Review Commission, Medicaid payment rates are on average about 73 percent of Medicare payments rates. Limiting payment raters to providers for QMBs and dual eligibles to the lower payment rates will generate about $5 billion in federal Medicaid savings. However, CBO assumes that about one-third of the combined federal and state savings will be offset by behavioral responses by providers in the Medicare program, increasing Medicare costs by about $2.9 billion. The net federal savings in the two programs will be about $2.1 billion.

* * * *

Supreme Court, U.S.
FILED
AUG 10 1998
OFFICE OF THE CLERK

No. 97-2079 (2)

IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

CALIFORNIA AMBULANCE ASSOCIATION
AND CALIFORNIA MEDICAL ASSOCIATION, *et al.*,
Petitioners,

v.

S. KIMBERLY BELSHE, DIRECTOR OF THE
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

and

DONNA E. SHALALA, SECRETARY OF THE
UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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IN THE

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OCTOBER TERM, 1997

No. 97-2079

CALIFORNIA AMBULANCE ASSOCIATION
AND CALIFORNIA MEDICAL ASSOCIATION, *et al.*,
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S. KIMBERLY BELSHE, DIRECTOR OF THE
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and

DONNA E. SHALALA, SECRETARY OF THE
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HEALTH AND HUMAN SERVICES,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

INTRODUCTION AND INTEREST OF THE AMICUS CURIAE [1]

Medicare has covered the health care needs of the elderly and disabled for more than 30 years, and pays

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[1] Letters from all parties consenting to the filing of this brief have been lodged with the Clerk of the Court. Pursuant to Rule 37.6, counsel for *amicus curiae* are not counsel for any party in this case, but appear *of counsel* on two petitions pending before the Court concerning the identical issue presented in this case: *Gilmore v. Belshe*, No. 97-1949, which was consolidated with this case before

roughly 80 percent of the federally-approved charges for medical services. Many Medicare beneficiaries are both poor and aged or disabled (known as Qualified Medicare Beneficiaries, or "QMBs"). State Medicaid programs have long been required to supplement the federal payment for the care of QMBs, satisfying the copayments otherwise expected from beneficiaries.

Significant numbers of willing physicians, among other health care providers and suppliers, are counted on to deliver the care those individuals require.[2] Medicare has secured the service of physicians, at least in part, by setting out in advance the terms on which they and other providers or suppliers would be paid. Medical professionals have rendered services in reliance on the government's promise to pay in accordance with statutory rules.

After disputes arose, physicians successfully enforced the terms of the statutes that govern payment for services to QMBs in all federal appellate decisions before August of 1997. Faced with the adverse decisions, state and federal governments persuaded Congress in that month to enact new rules that also purported to repudiate obligations already incurred. This and related cases ensued.

The implications of the decision at issue here (which upheld the retroactive act) extend beyond Medicare and the QMB context. The decision below effectively invites Congress and the state and federal governments to change the terms of payment for services already rendered whenever budgetary pressures make it convenient. The legislature would need only to declare a governing statute in

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the Ninth Circuit Court of Appeals below, and *Paramount Health Systems, Inc. v. Wright*, No. 97-2029. A petition for certiorari also has been filed in a third consolidated case from the Ninth Circuit, *Beverly Community Hospital Assn. v. Belshe*, No. 97-1947.

[2] The size of this population is significant. One in five elderly Americans, for example, lives in or near poverty. *See* D. Rowland and B. Lyons, "Medicare, Medicaid, and the Elderly Poor," *Health Care Financing Review* at 61 (Winter, 1996).

need of "clarification" and then proceed to change it and avoid all constitutional infirmity. Sizable federal outlays for programs such as Medicare and Medicaid present all too tempting a target for financially advantageous turnabouts.

If Congress may so easily defeat a provider's right to payment for work already performed, the stability of all government contracting programs can no longer be assured. Contractors such as physicians will be much less likely to participate in government programs, and the availability of services for Medicare beneficiaries and others whom the programs are meant to help—including the general public—will inevitably decline.

Amicus curiae, American Medical Association ("AMA"), is a private, voluntary nonprofit organization of physicians, founded in 1847 to promote the science and art of medicine and to improve the public health. The AMA is a national advocate on behalf of physicians and their patients in regard to legal and regulatory issues affecting the practices of medicine. Its 290,000 physician members practice in all states and in all fields of medical specialization, and include a significant number of physicians throughout the United States who serve Qualified Medicare Beneficiaries.

The AMA/State Medical Society Litigation Center ("Litigation Center") is a coalition of the AMA and 46 private, voluntary, nonprofit state medical societies formed in 1995 to represent the views of organized medicine in the courts.[3] The Litigation Center has been active

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[3] The member organizations are: Medical Association of the State of Alabama, The Alaska State Medical Association, Arkansas Medical Society, California Medical Association, Colorado Medical Society, Connecticut State Medical Society, Medical Society of Delaware, Medical Society of the District of Columbia, Florida Medical Association, Medical Association of Georgia, Hawaii Medical Association, Idaho Medical Association, Illinois State Medical Society, Indiana State Medical Association, Iowa Medical Society, Kansas Medical Society, Kentucky Medical Association, Louisiana State

in efforts to ensure proper implementation of QMB payment policies established by Congress. These efforts initially included attempts to resolve QMB payment issues through negotiations with the federal Health Care Financing Administration. When those attempts proved unavailing, the AMA continued with active assistance to state medical societies in litigation. The AMA lobbied actively, albeit unsuccessfully, against Congress' efforts to repudiate contractual QMB payment obligations through the Balanced Budget Act of 1997—the statute which now is the centerpiece of this litigation.

The American Medical Association, as *amicus curiae*, urges that the petition for certiorari be granted.

REASONS FOR GRANTING THE PETITION

As more fully set forth in the Petitioners' Statement, this case concerns the interaction of the Medicare program (42 U.S.C. § 1395 et seq.) and the Medicaid program (42 U.S.C. § 1396 et seq.) in paying for the health care of individuals designated as "Qualified Medicare Beneficiaries" or "QMBs."[4] Since 1988 and prior to

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Medical Society, Maine Medical Association, Massachusetts Medical Society, Michigan State Medical Society, Minnesota Medical Association, Mississippi State Medical Association, Missouri State Medical Association, Montana Medical Association, Nebraska Medical Association, New Hampshire Medical Society, Medical Society of New Jersey, New Mexico Medical Society, Medical Society of the State of New York, North Carolina Medical Society, North Dakota Medical Association, Ohio State Medical Association, Oklahoma State Medical Association, Oregon Medical Association, Pennsylvania Medical Society, Rhode Island Medical Society, South Carolina Medical Association, Tennessee Medical Association, Texas Medical Association, Utah Medical Association, Vermont State Medical Society, Washington State Medical Association, West Virginia State Medical Association, State Medical Society of Wisconsin, Wyoming Medical Society.

[4] The "QMB" population consists of two groups of Medicare beneficiaries: (1) "dual-eligibles" who simultaneously meet their state's eligibility criteria for full Medicaid benefits, including entitlement to have Medicaid pay, on their behalf, the prescribed

August 5, 1997, federal law required the State of California's Medicaid program to pay certain Medicare costs in full on behalf of QMBs, specifically including the 20 percent coinsurance for physician and other medical services covered under Part B of Medicare.[5]

Both the obligation to make payments on behalf of QMBs and a specific definition of the payments to be made are set forth in the statute. 42 U.S.C. §§ 1396(a)(10)(E), 1396d(p)(3). Rather than paying the statutorily prescribed Medi*care* amount, however, California limited these payments according to its own Medi*caid* fee schedule. Physicians in California challenged these payment limitations in litigation, following the path of physicians in other states with similar limitations. All four courts of appeal to have addressed the issue prior to 1997, as well as the District Court below, held that such payment limitations were unlawful and that physicians and other providers of health care services to QMBs were

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Medicare cost sharing amounts and (2) "pure QMBs" who meet alternative eligibility criteria under federal law which entitle them only to Medicaid payment, on their behalf, of the prescribed Medicare cost sharing amounts. *See* 42 U.S.C. § 1396d(p)(1).

[5] State Medicaid coverage of Medicare cost sharing amounts on behalf of "dual eligibles" was mandatory from the enactment of the original legislation in 1965, pursuant to 42 U.S.C. § 1396a(a)(15). That provision also permitted states to impose a responsibility to pay a nominal portion of the Medicare cost sharing on the dual eligible beneficiary. In 1986, states were authorized (but not required) to pay Medicare cost sharing on behalf of "pure QMBs" pursuant to legislation which, *inter alia*, added the current statutory definition of "Medicare cost sharing." Pub. L. 99-509 § 9403, 100 Stat. 2053 (1986). In 1988, Congress repealed § 1396a(a)(15), eliminated the statutory distinction between dual eligibles and pure QMBs, and made state payment of "Medicare cost sharing" (as defined in 1986) on behalf of all QMBs a mandatory component of approved state Medicaid plans. Pub. L. 100-360 § 301, 102 Stat. 748 (1988), as amended by Pub. L. 100-485 § 608, 102 Stat. 416 (1988); Pub. L. 100-647 § 8434(a), 102 Stat. 3805 (1988). The new statutes contained no provision analogous to § 1396a(a)(15) authorizing states to impose part of the payment responsibility on another party.

entitled to payment of the full Medicare rate for Medicare services rendered to QMBs.[6]

Congress interceded in the dispute by enacting Section 4714 of the Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 509 (August 5, 1997) ("Budget Act"). The Budget Act added new provisions purporting to "clarify" the authority of California and other states to limit benefits paid on behalf of QMBs. The Budget Act, at § 4714(c), also applies the new provisions retroactively, but only to health care providers that assert legal claims to payment for services rendered under prior law.

The Court of Appeals below concluded that Congress' expressed intent to "clarify" the prior law was entitled to "great weight." *Beverly Community Hospital Assn. v. Belshe*, 132 F.3d 1259, 1265 (CA9 1997). Viewing the new law as a clarification, the Court of Appeals concluded that Petitioners' constitutional objections to the retroactive effect of the Budget Act were obviated. *Id.* at 1266. The Ninth Circuit seems to have elevated this Court's holdings on judicial deference above constitutional takings and due process limitations, while simultaneously disregarding Congress' usurpation of the judicial function to direct the outcome of cases in which the United States is a party.

Beyond the reasons presented by Petitioners, *amicus curiae* AMA urges two additional reasons in support of the petition for a writ of certiorari to the Ninth Circuit.

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[6] *Rehabilitation Ass'n. of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444 (CA 4 1994); *Haynes Ambulance Serv., Inc. v. Alabama*, 36 F.3d 1074 (CA 11 1994); *Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886 (CA 3 1994); *New York City Health and Hospitals Corp. v. Perales*, 954 F.2d 972 (CA 2 1992); *California Ambulance Assn. v. Shalala*, No. CV96-2322 JSL (C.D. Cal. July 25, 1996) (entering summary judgment for plaintiffs in this case), reprinted in the Appendix to the Petition for Certiorari at 26-28.

I. CONGRESS' RETROACTIVE APPLICATION OF SECTION 4714 IS A DANGEROUS PRECEDENT FOR THE FUTURE INTEGRITY OF FEDERAL CONTRACTING PROGRAMS.

A. The Premises of Congress' "Clarification" Pose Issues of Great National Concern Affecting Federal Health Programs and All Government Contracts.

Section 4714, in the guise of a "clarification," authorizes the states—as federal agents and on their own behalf—to repudiate their statutory obligations to pay physicians and other medical care providers to receive the promised statutory payment for services performed under prior law. The enactment undermines the core integrity of government at both state and federal levels.

Section 4714 stands as a blueprint for future forays through the *Federal Reporter* in search of adverse judicial decisions that can be "clarified" into budget savings. This potential is of great concern with respect to the Medicare and Medicaid programs, which are very large components of the federal budget and which, concomitantly, are economically important to millions of beneficiaries and thousands of individuals who provide health care services to them.

Federal Medicare and Medicaid outlays totaled approximately $250 billion in fiscal year 1995, making the federal government the largest single purchaser of health care services in this country. U.S. House of Representatives, Committee on Ways and Means, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, Committee Print No. 104-14, 104th Cong. 2d Sess. (1996) (the "Green Book") at 134, table 3-1, and 896, table 16-13. The importance of the Medicare and Medicaid programs is particularly great to the lives and well-being of those who are the beneficiaries of the programs. Approximately 4.5 million Qualified Medicare Beneficiaries in the United States are directly affected by the enactment of Section 4714. *Id.* at 221-22, table 3-42. But the impact of Section 4714's

retroactivity extends to all Medicare and Medicaid beneficiaries—some 72 million in number, *id.* at 135-36, table 3-2, and 897-98, table 16-14, because the premises of Congress' action are not bounded by the QMB provisions of the law.

Approximately 788,000 physicians throughout the United States are active in the Medicare program. U.S. Department of Health and Human Services, *1996 HCFA Statistics* (September 1996) at 6, table 23. Their continued voluntary participation, and therefore the availability of services to patient populations such as QMBs, is essential to the fulfillment of the program's objectives. Their participation ultimately depends on the integrity of the federal government as a fair and reliable contractor for their services.

The issue for providers is not simply fee adjustments. Health care providers have become well accustomed to annual reductions in Medicare and Medicaid fees, a tradition that continued in the 1997 Budget Act. *See* Budget *Act*, §§ 4501-4505. Changes to reduce Medicare and Medicaid expenditures have been a principal focus of every budget reconciliation bill in recent history. *See* Green Book at 235-36, table 3-43. The legislative process is understood and accepted as one in which policies may be altered with future effect.

But Section 4714 reaches deeper—not only authorizing future changes in QMB payment policy, but voiding past obligations as well. It renders future commitments regarding the administration of Medicare and Medicaid of scant value. Moreover, health care is but one of many sectors of the economy substantially affected by the government's direct or indirect procurement activities, and nothing inherent in Section 4714 prevents the extension of its premises to other contracting activities.

This is not an instance in which Congress provided for short-term retroactive effect in order to avert strategic behavior on the part of those affected by a prospective change in the law. *Compare Pension Benefit Guaranty*

Corp. v. R.A. Gray & Co., 467 U.S. 717, 729-30 (1984) (retroactive application of ERISA withdrawal liability amendments deemed rational where employers could defeat the purpose of amendments by withdrawing during lengthy legislative process). Any such strategic behavior was an impossibility—the services were long ago provided. Rather, Congress has reached back over a period of years— as far as the statute of limitations on claims for payment —to take for itself the value of services provided in order to create budget savings.[7]

As this Court has stated previously, legislative repudiation of contractual obligations is not an affirmation of sovereign power; it is the antithesis of such power under our constitutional scheme. *United States v. Winstar Corp.*, 518 U.S. 839, 116 S.Ct. 2432, 2464 and n.38 (1996) ("sovereign acts" doctrine was meant to serve, not undermine, principle that government's contract relations are governed generally by law applicable to private contracts; suggestion that government may abrogate contracts it had come to regret in "regulatory" cases would render federal sovereignty of "very little use" in broad sphere of public activity); *Lynch v. United States,* 292 U.S. 571, 579-80 (1934) (valid contracts are property; rights against the United States arising out of a contract with it may not be abrogated simply to save money); *Perry v. United States,* 294 U.S. 330, 354 (1935) (Congress exceeded its power insofar as it attempted to override obligations created by bonds of the United States); *see also United*

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[7] Although the direct obligation to make Medicare cost sharing payment on behalf of QMBs is imposed on the states, the Medicaid scheme of federal financial assistance requires the federal government to reimburse California for 51 percent (approximately) of those amounts paid. *See* 42 U.S.C. § 1396b (statutory authority for federal financial assistance); 62 Fed. Reg. 62,613, 62,614 (November 24, 1997) (current federal financial assistance percentages). In order to receive federal matching funds, the California Medicaid plan must conform to federal law, including 42 U.S.C. § 1396a(a)(10)(E) which mandates coverage of Medicare cost sharing for QMBs.

States v. Larionoff, 431 U.S. 864, 879 (1977) (suggesting that constitutional concerns of *Lynch* and *Perry* would be implicated by congressional action to reduce armed forces pay for services already performed).

Whatever the wisdom, as a matter of policy, of Congress' decision to change the basis of payment for QMBs for the future, its determination to relieve itself of the obligation to make full payment for services already performed substitutes legislative fiat for the orderly administration of federal contract programs under law. "If retroactive laws change the consequences of transactions long closed, the change can destroy the reasonable certainty and security which are the very objects of property ownership. . . . Both stability of investment and confidence in the constitutional system . . . are secured by [constitutional] restrictions against severe retroactive legislation." *Eastern Enterprises v. Apfel*, —— U.S. ——, 118 S. Ct. 2131, 2159 (1998) (Kennedy, J., concurring in the judgment and dissenting in part).

B. This Case Presents Important Corollary Considerations to This Court's Recent Decision in *Eastern Enterprises*.

This Court recently affirmed its view that retroactivity is "generally disfavored in the law, in accordance with fundamental notions of justice that have been recognized throughout history." *Eastern Enterprises v. Apfel*, —— U.S. ——, 118 S. Ct. 2131, 2151 (1998). The concern raised in *Eastern Enterprises* regarding unjust interference with legitimate and settled expectations is most acute when the character of the governmental action is revealed not only to place a disproportionate burden on one group of individuals, but to create, in turn, a direct fiscal benefit for the federal government as purchaser of those individuals' services.

This case presents a clear and useful opportunity to bring the *Eastern Enterprises* analysis to bear upon programs that involve the federal government's own obliga-

tions. The instant case presents compelling comparisons and contrasts to *Eastern Enterprises* which suggest not only a strong foundation on which to amplify a constitutional "takings" analysis but also an appropriate case in which to further explore the limits of retroactive legislation, whether under a takings or a due process framework.

The effect of Section 4714 is substantial—it completely extinguishes physicians' vested rights to payment under the prior statutory scheme. It works a permanent deprivation of those assets. Congress has directly specified the assets that physicians must forfeit, and the law's effect depends solely upon the confiscation of those assets. That is, they must donate a portion of their labors by giving up their identified claims. *See United States v. Security Industrial Bank*, 459 U.S. 70, 75 (1982) (amendment to Bankruptcy Act permitting debtors to avoid certain liens would work a "complete destruction" of a property right if applied retroactively); *Armstrong v. United States*, 364 U.S. 40, 49 (1960) (compulsory transfer of property to government rendering liens unenforceable constitutes a "taking" within the meaning of the Fifth Amendment; government may not force some people alone to bear burdens which should be borne by the public as a whole).

Significantly, unlike in *Eastern Enterprises*, the asserted taking here is *by* the government, not a separate entity. *See* 118 S. Ct. at 2162 (Breyer, J., dissenting). The extinguishment of physicians' claims serves only the government's self-enrichment. Section 4714 has no colorable purpose to adjust private relationships in order to improve the public condition. *Cf. Webb's Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 15, 163-64 (1980) (exaction of a forced contribution of private property to government cannot be viewed as an adjustment of the benefits and burdens of economic life to promote the common good). Likewise, the statute has no remedial purpose. *Compare Usery v. Turner-Elkhorn Mining Co.*, 428 U.S.

1, 18 (1976) (legislation requiring coal companies to bear liability for illnesses of former workers not irrational because companies and their customers had received the benefit of former workers' labor).[8] Section 4714 is purely a budgetary measure. It "remedies" only Congress' need to reduce federal expenditures. *See* Appendix to Petition for Certiorari at 44-48 (Congressional Budget Office estimate of reduction in federal outlays resulting from Section 4714).

Further, it cannot be said that physicians had any reasonable expectation that the federal government would impose a reduced rate of payment after the services were rendered,[9] and the fact that physicians were paid something does not mean that the lack of full payment is not a significant economic burden.[10] Section 4714 impairs substantive rights which were acquired before its enactment, by physicians' performance of services in reliance on the government's statutory offer. *See Louisville Joint Stock Land Bank v. Radford*, 295 U.S. 555 (1935) (amendment to Bankruptcy Act depriving mortgagees of previously acquired lien rights constitutes a taking in violation of the Fifth Amendment). There is no logical

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[8] This case is quite the opposite. Here, it is the federal and state governments that have received the benefit of physician services, but now seek to retroactively avoid the obligation to pay the promised rate in full.

[9] There is no agreement to future payment reductions here that can be analogized to the promises of lifetime benefits asserted (and ultimately found unpersuasive) in support of the challenged legislation in *Eastern Enterprises*. *See* 118 S.Ct. at 2152. Moreover, as this Court has stated previously, Congress' express reservation of rights to amend the Social Security Act does not extend to impairment of contractual obligations which confer vested rights. *Bowen v. Public Agencies Opposed to Social Security Entrapment*, 477 U.S. 41, 51-52 (1986).

[10] Medicare fee schedules, to begin with, are below the levels that commercial insurers deem "usual and customary." *See, e.g.*, Physician Payment Review Commission, *Physician Payment Under Medicaid*, No. 91-4 (1991) at 36.

dividing line between Section 4714 and a future law declaring prior services to have been rendered for free. A frightening "slippery slope" exists that only rejection of congressional power to repudiate the government's obligations can avoid.

Finally, unlike the suggestion made in *Eastern Enterprises*, 118 S.Ct. at 2150, physicians have no ability to enter into private contracts of indemnification or otherwise adjust their relationships with QMBs in response to the retroactive "clarification" of federal payment policy. Apart from the fact that the physicians have already performed their part of the bargain, Congress wholly foreclosed any private remedial measure by enacting, as part of Section 4714, a specific prohibition on seeking the balance of the promised payment from the beneficiaries. Budget Act § 4714(a).

Amicus curiae submits that the circumstances of Section 4714 present questions of compelling national interest, the same caliber as those recognized in *Eastern Enterprises*. For this reason, the writ of certiorari should issue to review the decision of the Ninth Circuit.

II. CERTIORARI SHOULD BE GRANTED TO RESOLVE THE QUESTION OF "DEFERENCE" OWING TO A LATER CONGRESS' ATTEMPTED RETROACTIVE REPUDIATION OF AN ENACTING CONGRESS' INTENT.

The Ninth Circuit below and, with greater expressed reluctance, the Seventh Circuit in *Paramount Health Systems, Inc. v. Wright*, 138 F.3d 706, 710-711 (CA 7 1998), concluded that this Court's precedents required deference to Congress' 1997 interpretation of its 1986 intent regarding QMB payments. Apart from the plain fact that the clarification comes eleven years after the fact, good reasons exist to question this newly-revealed legislative discernment. These reasons flow, *inter alia*, from the context in which the QMB provisions originally were enacted, which suggests that Congress made clear choices to ensure that QMBs would receive full Medicare benefits,

and did so as part of an overall legislative scheme to regulate Medicare supplemental insurance. These circumstances argue against giving unquestioning deference to Congress' later interpretation and in favor of Petitioners' request for clarification of the standard of review in such cases.

A. There Are Important Public Policy Grounds for Congress' Historical Attention to the QMB Population.

Congress' historical interest in protecting the QMB population is well grounded. The population is diverse but has substantial health care needs.[11] By definition, all QMBs are individuals of limited economic means. They include both elderly Medicare beneficiaries and non-elderly Medicare beneficiaries who are disabled. The disabled and the so-called "frail elderly" (those aged 85 and over) are more likely to be eligible for both Medicare and Medicaid. Compared to the general Medicare population, QMBs are more likely to be minorities, female, and living alone.

QMBs report significant health problems. Over forty percent of these individuals have a cognitive or mental impairment, compared to nine percent of the non-QMB Medicare population. Half of Medicare beneficiaries with Alzheimer's Disease or a psychiatric disorder, and two-thirds of Medicare beneficiaries with mental retardation, are QMBs. This population is twelve times more likely than non-QMB Medicare beneficiaries to reside in a nursing home or other institution. Similarly, QMBs are more likely than their non-QMB counterparts to have chronic and/or serious medical conditions, such as stroke, chronic heart disease, diabetes, broken hips, or paralysis. Half of

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[11] The description of the QMB population presented in this section is drawn from: Health Care Financing Administration, *A Profile of Dually Eligible Beneficiaries* (March, 1997). The Health Care Financing Administration is the component of the U.S. Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

QMBs describe their own health status as "fair" or "poor," twice the rate of non-QMB Medicare beneficiaries.

QMBs face problems of access to health care directly related to their inadequate financial resources. They cannot afford to pay the premiums for Medicare Part B, the voluntary portion of Medicare which covers physician and other services outside of a hospital. They are burdened by the statutorily-imposed deductibles and coinsurance requirements when they use Medicare-covered services. More affluent Medicare beneficiaries can relieve this burden by purchasing commercial Medicare supplements (so-called "Medigap" policies). Through the original QMB provisions, Congress undertook a deliberate effort to provide needed supplemental coverage for QMBs through Medicaid. *See* H.R. Rep. No. 99-727, 99th Cong., 2d Sess. 105-106, *reprinted in* 1986 U.S.C.C.A.N. 3607, 3695-96 (1986).

B. Because the Acts of Congress in 1986 and 1988 Conflict With Its "Clarifying" Words in 1997, the Ninth Circuit's Deference to the Later Enactment Merits Close Scrutiny.

Congress did not, however, embark on its efforts to assist QMBs by relegating them to a lesser program of benefits. QMBs have always been Medi*care* beneficiaries in the first instance. For this population, state Medicaid programs function in the same manner as a commercial insurer, paying benefits which are supplemental to those of the Medicare program.

Had Congress intended to bring QMBs under the control of state Medicaid programs (and set standards for payment at Medicaid rates), it could have done so directly by renouncing Medicare's primary responsibility for the poor elderly and placing those individuals on the state Medicaid rolls when it made state coverage of QMB cost-sharing mandatory in 1988. That Congress did not do so is consistent with its original intent in enacting the Medicare program in 1965—to address the disparity in health

care access between the elderly with sufficient financial resources and those without. It would be illogical to conclude that Congress, in *expanding* the scope of individuals for whom supplemental coverage would be available through Medicaid (i.e., QMBs), set out to subvert its original design of a single-tiered health insurance program available to all eligible persons on an equal basis.[12]

Beyond its election to maintain the status of QMBs as Medicare beneficiaries, Congress specifically directed the states to pay deductibles and coinsurance for Medicare services provided to QMBs whether or not the specific services otherwise would be covered by the state's Medicaid plan. 42 U.S.C. § 1396d(p)(3). Logically, if Congress had envisioned that a state would be required to pay the Part B cost sharing obligations of Medicare beneficiaries only to the extent of the fees authorized in its Medicaid plan, it would have had no reason to require the state to pay the coinsurance charges for services that are *not* in its plan (i.e., for which the state pays nothing). Instead, the requirement that the states make coinsurance payments for the full panoply of Medicare services is part and parcel of a statutory scheme in which the states are to provide complete supplemental *Medicare* coverage, which includes payment of all coinsurance costs on behalf of QMBs.

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12 This was a touchstone principle in the Second Circuit's first impression analysis of the pre-1997 QMB payment provisions. *Perales*, 954 F.2d at 859 ("Congress sought to avoid a wealth-based, two-tiered system of health care for the elderly and certain disabled and indeed wanted to integrate *all* of those who were Medicare-eligible into the existing health care system.") (emphasis in original). Indeed, a 1997 report prepared by the federal Health Care Financing Administration devotes some 25 pages to a comparison of the demographic, health status, and health spending characteristics of QMBs to those of the *Medicare* population as a whole. Health Care Financing Administration, *A Profile of Dually Eligible Beneficiaries* (March, 1997). No other comparison would make sense—the QMB population is a subset, albeit a less affluent subset, of the elderly and disabled population for whom Congress created the Medicare program.

As it was expanding supplemental coverage for low-income Medicare beneficiaries (i.e., QMBs), Congress simultaneously increased its regulation of private supplemental insurance (so-called "Medigap") policies.[13] In the same 1988 enactment which mandated state supplementation of coverage for QMBs, Congress mandated more extensive federal standards for commercial Medigap policies, including minimum benefit standards.[14] Pursuant to the regulatory scheme initiated in 1988, approved Medigap policies must conform to one of ten standardized benefit designs. Even the most basic of those designs includes full coverage of Part B coinsurance.[15] This 1988 effort to ensure that supplemental insurance for *all Medicare* beneficiaries would cover Part B cost sharing is inconsistent with the retroactive "clarification" of intent in the 1997 Budget Act.

Finally, Congress in 1989 confronted ongoing concerns over low rates of physician participation in state Medicaid programs, mandating a study of the impact of state Medicaid payment policies on the availability of physician serv-

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13 Nearly nine out of ten Medicare beneficiaries hold some form of supplemental insurance to augment their Medicare coverage. Physician Payment Review Commission, *Annual Report to Congress* (April, 1997) at 317. This insurance comes in three forms: individually-purchased commercial Medigap insurance, employer-provided retiree health benefits, and Medicaid. Supplemental insurance covers items, services, and cost sharing that Medicare does not, including deductibles and coinsurance. "Such insurance provides valuable financial protection to Medicare beneficiaries and is associated with better access to care for those beneficiaries who have it." *Id.* For most QMBs, Medicaid is the only available source of supplemental insurance to assure such access.

14 42 U.S.C. § 1395ss, as amended by Pub. L. 100-360 § 221(d), 102 Stat. 744 (1988), Pub. L. 101-234 § 203(a), 103 Stat. 1982 (1989), and Pub. L. 101-508 § 4351(a), 104 Stat. 1388-125 (1990).

15 The federal certification program is based on standards developed by the National Association of Insurance Commissioners. Those standards require all Medigap policies to cover certain "Core Benefits," including Part B coinsurance. *See* 57 Fed. Reg. 37,985, 37,991 (August 21, 1992).

ices for federally-insured populations. Completed in 1991, the study confirmed that inadequate payment rates were the most prevalent reason for inadequate access to physician services under Medicaid.[16] It is difficult to reconcile Congress' 1997 view that, in 1986, it had authorized states to impose Medicaid payment limits on Medicare services to QMBs with its contemporaneous efforts to define problems caused by inadequate Medicaid payment rates.

Congress' actions in 1986 and 1988 are plainly different from its words in 1997. Both legal and civic interests in the regularity of governmental business dealings, as well as interests in ensuring the integrity of benefit programs reaching millions of lives, argue for close scrutiny when Congress seeks to capriciously gainsay the motivations of its original legislative choices. Petitioners' request for guidance regarding the deference due under this Court's precedents to the later-discovered interpretation of the 1997 Congress merits review.

CONCLUSION

For the foregoing reasons and for the reasons stated in the petition of the California Ambulance Association, the California Medical Association, et al., *amicus curiae* American Medical Association respectfully urges that a writ of certiorari issue to review the judgment of the Ninth Circuit in this matter.

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[16] Physician Payment Review Commission, *Physician Payment Under Medicaid*, No. 91-4 (1991) at 21-23. The study reported that state Medicaid fees, overall, averaged about 64 percent of Medicare allowed charges for providing identical services. *Id.* at 35. In evaluating the results, the PPRC observed that Medicaid recipients must obtain physician services in the same market as persons with private health insurance, and cited evidence that, as the discrepancies between Medicaid fees and fees paid by commercial insurers and Medicare are reduced, the numbers of physicians participating in Medicaid, and the proportion of their capacity that physicians will devote to Medicaid patients, increases. *Id.* at 38-39.

Respectfully submitted,

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FILED
AUG 28 1998
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 97-1947, No. 97-1949, No. 97-2079

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASS'N, *Petitioner*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, *Respondent*.

CALIFORNIA AMBULANCE ASS'N and CALIFORNIA MEDICAL ASS'N, et al., *Petitioners*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, and DONNA E. SHALALA, Secretary, United States Dept. of Health and Human Services, *Respondents*.

RICHARD GILMORE, et al., *Petitioner*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, and DONNA E. SHALALA, Secretary, United States Dept. of Health and Human Services, *Respondents*.

On Petition for Writ Of Certiorari To The United States Court of Appeals for the Ninth Circuit

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BRIEF IN OPPOSITION TO PETITIONS FOR WRITS OF CERTIORARI

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QUESTION PRESENTED

Is California's interpretation of 42 U.S.C. section 1396a(n) correct in light of the fact the Secretary of the Department of Health and Human Services shared that interpretation, that Congress ratified that interpretation by clarifying legislation and that the interpretation is consistent with the statutory scheme regarding qualified medicare beneficiaries?

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PREFACE

S. Kimberly Belshé, Director ("California") of the Department of Health Services of the State of California hereby files this Brief in Opposition to the petitions for writs of certiorari filed by the Petitioners in California Ambulance Ass'n and California Medical Ass'n v. S. Kimberly Belshé et al., No. 97-2079 (herein "Associations"), Richard Gilmore, M.D., et al. v. Donna E. Shalala, et al., No. 97-1949 (herein "Gilmore", and Beverly Community Hospital Ass'n, et al. v. S. Kimberly Belshé. No. 97-1947 (herein "Beverly"). The Secretary of the United States Department of Health And Human Services will be refereed to as the "Secretary."

INTRODUCTION

The brief in opposition filed by California to the petitions for writ of certiorari filed by the three Petitioners is combined because the statutes, cases and issues in question in these petitions are essentially identical. Therefore, no purpose would be served by filing separate, identical briefs in opposition to each petition.

California does not dispute the jurisdictional statements (California Ambulance Ass'n, p. 1, Gilmore, p. 1, Beverly, p. 1), the constitutional provisions and statutes involved, (California Ambulance Ass'n, p. 1, Gilmore, p. 1, Beverly, p. 1), set forth in each petition. California does not dispute the description by each petitioner of the sequence of events in the trial court and the Ninth Circuit. (Gilmore, p. 8-10, California Ambulance Ass'n, p. 8-10, Beverly, p. 2-5,) California does not agree with the questions presented by the Petitioners.

SUMMARY OF ARGUMENT

The petitions do not state any compelling reason under Rule 10 for this Court to grant certiorari. There is no conflict among the circuits because the two circuit decisions after the enactment of section 4714 reached the same result. California and the Secretary are correct in their interpretation of the role section 1396a(n) plays in the payment permitted the states to providers regarding crossover claims. It is not convincing to argue that Congress did not really "clarify" prior legislation because Congress did not narrowly make the clarification but did its best to put the issue at rest. This Court has a reasonable and venerable rule regarding the weight it gives to Congress's clarification of statutory policy, which was applied properly by both circuits and which does not need further elaboration, and which is not in conflict with any other maxim of statutory interpretation. Whatever life the Klein decision might have, this action is not the place to explore its vitality because Congress did not create a rule of decision that would bind the judiciary. Finally, in California no provider under Medicaid had a reasonable expectation that it would receive 100% of the amount it charged for the services it rendered to the beneficiaries of the Medicaid Program who are the subject of this action.

STATEMENT OF THE CASE

STATUTORY AND REGULATORY BACKGROUND

1. Medicaid/Medi-Cal.

The Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., was enacted by Congress in 1965. Medicaid is a need-based cooperative federal and

state cost sharing venture that enables each state "as far as practicable under the conditions in such State," to provide necessary medical assistance to families and individuals with insufficient income and resources. See, Pub. L. No. 89-97, 79 Stat. 286 (1965), as amended, 42 U.S.C. 1396 et seq. A state is not required to participate in the Medicaid program, but if it chooses to participate it must comply with the Medicaid Act and its implementing regulations. 42 U.S.C. 1396c.

Under Medicaid, each state has a fee schedule or methodology that establishes a rate for every item or service covered under the state's Medicaid plan. California's Medicaid rates are almost always less than the allowable charge for services under Medicare. Participating providers must accept the Medicaid payment, together with any nominal co-payment obligations, as payment in full for services and amounts covered under the state plan.

The methods, procedures and payment levels for Medicaid services must be under 42 U.S.C. § 1396a(30)(A):

> "as necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Therefore, during the period covered by this litigation, the states were obligated to maintain Medicaid rates at a level sufficient to attract sufficient providers to

provide items and service to the relevant patient (including the QMB) population. The Petitioners (and Amicus) do not contend that the level of the Medicaid rates is inconsistent with section 1396a(30)(A).

Medicaid is the payer of last resort, which is to say that "other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 146, 99th Cong., 2d Sess. 1, 312 (1986), reprinted in 1986 USCCAN 42, 279. See, 42 U.S.C. 1396a(a)(25). The Secretary's regulations require the states to reimburse a provider only to the extent that the state's Medicaid rate exceeds the third-party payment. 42 C.F.R. 433.139(b)(1). The Secretary views Medicare as a third party insurer under these regulations.

2. Medicare.

Enacted in 1965, Title XVIII of the Social Security Act is commonly known as the Medicare Act. See, Pub. L. No. 89-97, 79 Stat. 291 (1965), as amended, 42 U.S.C. 1395 et seq. Individuals who are at least 65 years of age or disabled (and meet certain other eligibility requirements) are automatically covered in Part A of the Medicare program, which provides reimbursement for inpatient hospital care and related post-hospital, home health and hospice care for aged and disabled beneficiaries. 42 U.S.C. 1395c-1395i-4 (1995). Under Part A, the federal government pays a health care provider's reasonable cost for covered services, less deductibles and coinsurance. Medicare beneficiaries who receive Part A services are responsible for paying "deductibles" (a fixed and limited amount of money toward the charge of hospital care) and "coinsurance" (a percentage of reasonable cost for each day of care after the first sixty

days). Some individuals also pay a premium. 42 U.S.C. § 1395e; 42 C.F.R. § 409.80. These are referred to herein as "Medicare cost-sharing amounts."

Part B is a voluntary insurance program pursuant to which eligible individuals may purchase supplementary insurance for hospital out-patient services, physician services, and other medical services not covered under Part A. 42 U.S.C. 1395j; 42 U.S.C. 1395l(a)(1); 42 U.S.C. 1395l(b).

Generally the federal government pays 80% of the allowable charges for Medicare beneficiaries who receive Part B services. The beneficiaries are responsible for paying deductibles (a fixed and limited amount), and coinsurance or copayments (a percentage of the reasonable value of the service). 42 U.S.C. § 1395e; 42 U.S.C. § 1396d(p)(3). The amounts beneficiaries are responsible for are referred to above and throughout - as with Part A - as "Medicare cost-sharing amounts."

3. The QMB Provisions.

A. The QMB Program.

Between 1967 and 1986, states were required to pay cost-sharing only on behalf of persons eligible for both programs. In 1986, Congress broadened the class of persons eligible for such coverage beyond these dual eligible. Pub.L. No. 99-509, §9403, 100 Stat. 2053-2056. The 1986 amendments provided that "at the option of a State" the State Plan could "provide for making medical assistance available for medicare cost-sharing" for "qualified medicare beneficiaries." *id.* §9403(a)(3), 100 Stat. 2053.[1] (42 U.S.C. § 1396(a)(10)(E)(i).)

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1. At the time, QMB's were defined as persons (1) who were eligible for Medicare Part A but not otherwise eligible for Medicaid,

The states' obligations with regard to this new category of individuals were addressed in two subsections of section 9403. Section 9403(c)(2) provided that "the medical assistance made available to a qualified medicare beneficiary * * * shall be limited to medical assistance for medicare cost-sharing * * * subject to the provisions of subsection (n) [of this section]." Pub. L. No. 99-509, § 9403(c), 100 Stat. 2054 (codified in clause (VIII) in the matter following 42 U.S.C. § 1396a(a)(10)(F)) (emphasis supplied). The new Section "n," -- Section 9403(e) of the Public Law, (codified at 42 U.S.C. 1396a(n)) -- was entitled "Payment Amounts." It specified that states "may" provide for payment of Medicare cost-sharing in an amount "that results in the sum of such payment amount and any amount of payment made under [Medicare] * * * exceeding the amount that is otherwise payable under the State [i.e. Medicaid] plan * * *." Id. § 9403(e), 100 Stat. 2055. Thus, Congress expressed its intention that states not be required, although they might choose, to pay coinsurance on behalf of QMBs in amounts that exceeded the charges "otherwise payable" under the state's approved Medicaid plan.

B. 1998: Expansion of the QMB Program

The 1986 amendments, allowing states to pay cost-sharing for pure QMBs, had a limited practical effect: By 1988, only one state had chosen to purchase Part B Medicare for pure QMBs. H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess. 59 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 882. It was in 1988 that Congress for

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(2) whose income did not exceed an amount set by the state but not more than 100% of the poverty line, and (3) whose resources did not exceed the Supplemental Security Income (SSI) program's maximum. *id.* §9403(b) (42 U.S.C. § 1396d(p)(1).)

the first time mandated that states make medicare cost-sharing available to persons not otherwise eligible for Medicaid assistance, *i.e.*, to pure QMBs. Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748 (deleting "at the option of the State" from 42 U.S.C. § 1396a(a)(10)(E)(i)). In the same bill that Congress thus first mandated coverage of pure QMBs, it also expanded the pool of those eligible to be QMBs by doubling the amount of resources an individual could own without losing QMB status. *Id.* § 301(c)(2) (codified at 42 U.S.C. §1396d(p)(1)(C)).

When it imposed these new obligations on the states, Congress was aware of the prior, practical construction of the law that states had discretion whether to make cost sharing payments over the Medicaid fee amount:

> It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligible, some States pay the coinsurance even if the amount Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. Under the Committee bill, States would not be required to pay the Medicare coinsurance in the case of a bill where the amount reimbursed by Medicare -- i.e., 80 percent of the reasonable charge -- exceeds the amount Medicaid would pay for the same item or service. However, if a State chooses to pay some or all of the co-insurance in this circumstance, Federal matching funds would, as under current law, be available for this cost.

H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 884.

Later in 1988, Congress changed the statutory definition of QMB to its current form, so that now it

includes both pure QMBs and dual eligible. Pub. L. No. 100-647, § 8434(a), 102 Stat. 3342, 3805. The accompanying House Conference Report explained that all Medicare-eligible persons with income and resources under the limits set by 42 U.S.C. 1396d(p)(1), are to be considered QMBs, "whether or not they are otherwise eligible for Medicaid." H.R. Conf. Rep. No. 1104, 100th Cong. 2d Sess. (1988), *reprinted in* 1988 U.S.C.C.A.N. 5048, 5344.

Finally, in 1989, Congress amended the Medicare Act to require that physicians treating QMBs accept assignment from Medicare, thereby precluding the billing of QMBs in excess of the fee schedule amount set by Medicaid. Pub. L. No. 101-239, § 6102, 103 Stat. 2106 (1989) (codified at 42 U.S.C. § 1395w-4(g)(3)(A)). In so doing, the House Report considered the current practices of the States, as approved by the Secretary, regarding Medicaid payment of coinsurance for QMBs and ratified this practice: "The Medicaid programs typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question * * *. The Committee bill * * * does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims. H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2090 (emphasis added).

C. California's Implementation - Part A.

California's policy regarding reimbursement for providers of inpatient hospital services has been consistent since the enactment of California Welfare & Institutions Code § 14109.5 (effective January 1, 1982). However,

California's ability to effectuate the policy has been dependent on its Medicaid agency's, the Department of Health Services, ability to identify comparable services, which initially was not possible with hospital inpatient services. In 1992, section 14109.5 was amended to direct the Department to look toward Medicare itself for establishing rates for comparable hospital inpatient services, which the Department did pursuant to 42 U.S.C. § 1396a(a)(13)(A) ("the Boren Amendment") (now repealed, P.L. 105-33, 111 Stat. 251, sec. 4711 (1997)). When the Department had completed its required Boren Amendment analysis, it concluded that the amounts paid - as contrasted with the rates charged by the providers - by Medicare were reasonable and adequate reimbursement for the providers of inpatient hospital services to beneficiaries eligible for both Medicare and Medi-Cal. Accordingly, in 1994 the Department adopted the Medicare level of payment as its standard for reimbursement for services rendered to beneficiaries who are eligible for both Medicare and Medi-Cal.

D. California's Implementation - Part B.

Prior to January 1, 1982 California paid all deductibles and coinsurance costs on behalf of all enrollees under the Part B buy -in agreement. California's buy-in agreement was amended and approved by the Secretary, effective January 1, 1982, capping payment under the buy-in agreement to the maximum Medi-Cal (Medicaid) payment for the same service. (Samuel v. California Department of Health Services (N.D. Cal. 1983) 570 F.Supp. 566, as modified, 572 F.Supp. 273.)

Samuel held that under a buy-in agreement when California pays the Part B premiums the Medicare Part B coverage thereby becomes part of the Medi-Cal program's

scope of benefits. By holding that a health care provider that accepts a crossover beneficiary therefore must accept the patient as a Medi-Cal patient and by prohibiting providers from seeking further reimbursement from beneficiaries, the Court approved California's rate limitation for Part B services. (Samuel at p. 573.)

Hence, notwithstanding the expansion in the class of beneficiaries a state may include in its Medicaid state plan and buy-in agreement, Samuel holds that the program remains a Medicaid program pursuant to which a state may purchase some or all of the benefits provided through Medicare Part B (and by extension Part A) and is not required to reimburse providers at higher than the Medicaid rate.

E. The Litigation.

Once Congress passed the 1988 legislation, providers saw an opportunity to close the gap between what had always been a difference in payment and which had been approved in California under Samuel. Four Circuit Courts held, with dissents and with different views on the meaning of 1396a(n) and the policy motivating Congress in 1986 and 1988, that the providers were entitled to the higher Medicare rate. Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444 (4th Cir.), (Niemeyer, J. dissenting), cert. denied, 116 S. Ct. 60 (1995) ("Kozlowski"); Haynes Ambulance Service v. Alabama, 36 F.3d 1074 (11th Cir. 1994) ("Haynes"); Pennsylvania Medical Soc'y v. Snider, 29 F.3d 886 (3d Cir. 1994) ("Snider"); New York City Health & Hosp. Corp. v. Perales, 954 F.2d 854 (2d Cir.), (Cardamone, J., dissenting) (cert. denied, 113 S. Ct. 461 (1992) ("Perales").

Later, in California, Judge Letts of the Central District agreed with the result of these decisions and entered judgment for the providers in the three cases in this action. In the Northern District, Judge Legge in Dameron Physicians Medical Group, Inc. v. Shalala, et al., 961 F.Supp. 1326 (N.D.Cal. 1997) reached the opposite conclusion:

> "In the absence of a clear answer in the statutory language, and in light of the United States Supreme Court's decision in Chevron and the Ninth Circuit's decision in Stephenson, this court must accept the defendants' interpretation of the statutes at issue. California may cap its payments at the Medi-Cal maximum levels." (Id. at 1333.)

The district courts in Snider, Haynes, and Perales had agreed also with the position taken by California and the Secretary.

Aside from the conflicting district court decisions, the various positions taken in the opinions justify the rule that deference should be given to the Secretary when the statutory scheme is unclear. In Snider, the court concluded that Congress' policy to make the crossover program mandatory was to force the states to expend a projected windfall on the elderly poor. (Id. at 902) Whether that intent was true, there was no legislative history Congress wanted the money to go to providers. In Perales, the court concluded Congress' policy was to prevent a two tiered reimbursement system for crossover beneficiaries. (Id. at 858-859.) However, the Perales court could only justify Congress' policy based upon tenuous inferences drawn from Congress' 1965 policy relating to the difference between private pay and

Medicare patients. (Ibid.) Haynes adopted Snider in its analysis. In Kozlowski, the court held, with Justice Niemeyer offering a different analysis, that the permissive language in section 1396a(n) is limited to the option the states possessed prior to 1988 to pay a higher Medicare benefits to "pure" QMBs than to dual eligible. The irony, in light of the Petitioners' argument that any attempt at clarification of policy by Congress should be ignored by the judiciary or given little weight, is that the circuits justified their interpretation of QMB reimbursement scheme based upon a search for the policy of Congress.

F. The Balanced Budget Act of 1997.

Given the litigation that developed regarding Congress's intention in the 1988 legislation, the welter of conflicting district and court of appeals decisions, and the conflict between the providers, on the one hand, and the states and Secretary on the other, Congress enacted section 4714 of the Balanced Budget Act of 1997 ("BBA") (P.L. 105-33, 111 Stat. 251, eff. August 5, 1997) entitled a "clarification regarding state liability for medicare cost-sharing." Congress amended section 42 U.S.C. section 1396a(n) to read as follows:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred related to payment for deductible, coinsurance, or copayments for medicare cost sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

Congress also provided that its clarification applied to existing litigation:

> (c) EFFECTIVE DATE.--The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is subject of a law suit that is based on the provisions of section 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act."

The Committee of Conference statement describes Congress understanding of pre-BBA law:

> "State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare, (dual eligible) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards.) The amount of the required payment has been the subject of some controversy.State Medicaid Programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to pay either (1) the full Medicare deductible and coinsurance amounts or (2) cost-sharing charged only to the extent that the Medicare provider has not

received the full Medicaid rate for an item or service. Some courts have forced state medicare programs to reimburse Medicare provider to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals." (See H. Conf. Rep. No 105-217, 105th Cong. 1st Sess. 870-870 reprinted in 1997 U.S.C.C.A.N 176, 491-492)

The report then concluded that the amendment:

"Clarifies that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state' Medicaid program would have paid for such service to a recipient who is not a QMB. Specifies that the Medicare payment plus the state' Medicaid payment will be considered payment in full and the QMB will not be liable for payment to a provider or managed care entity. Additionally provides that any sanction for excess charges that may be imposed on a provider or managed care entity under Medicare may be imposed for making excess charged under Medicaid. Applies to items and services furnished on or after the date of enactment. In the case of payment that is subject to a law suit that is pending as of the date of enactment, or initiated after the date of enactment, applies to items and services furnished before the date of enactment." (Ibid.)

G. Wisdom comes eventually - Beverly and Paramount decisions in favor of the Secretary and California.

The Ninth Circuit decided the case that is the subject of these petitions, Beverly Community Hospital Ass'n v. Belshe, 132 F.3d 1259 (9th Cir. 1997) and the Seventh Circuit decided Paramount Health Systems, Inc. v. Wright, 138 F.3d 706 (7th Cir. 1998). Both of these courts recognized that Congress' intent pre-BBA was unclear in relation to QMBs and that, giving deference to Congress' expression of clarification in section 4714, weighed the balance in favor of the interpretation taken by California and the Secretary.

In Beverly the court pointed out that "Section 1396a(n) is a superb example of the baffling nature of [the Medicaid and Medicare acts]." (Id. at 1266.) "It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification." (Ibid.) In Paramount, although the court mused whether section 4714 really was a proper clarification, eventually it concluded the place of section 1396a(n) in Congress' scheme of reimbursement was sufficiently ambiguous to accept the interpretation of California and the Secretary, to wit:

> The Act is a hopeless muddle so far as [QMB] reimbursement is concerned, and while it seems to us that [the health providers have] the better interpretation, there is sufficient ambiguity to require us to defer to the government." (Id. at 711.)

Beverly and Paramount have been followed in McCreary, M.D. et al. v. Offner, et al., 1 F.Supp. 2d 32 (D.D.C. 1998) in which Judge Friedman of the District of Columbia District Court held:

> Whether one scrutinizes the clarifying claims of Section 4714 with a harsher gaze or not, one thing is clear: the law regarding state liability to pay for the health services provided to QMBs has never been crystal clear. Section 4714 has certainly provided clarification where it was needed. For this reason, the Court concludes that applying Section 4714 retroactively, as Congress directed, is not impermissible under the Constitution." (Emphasis supplied.) (Id at 49.)

The question now is whether this Court should accept the Petitioners' invitation to enter this "muddle" and resolve the issue.

REASONS FOR THIS COURT NOT TO GRANT THE PETITIONS FOR CERTIORARI

1. Although California and the Secretary are correct in their interpretation of section 1396n(a) in the context of QMBs and the evolution of their eligibility for Medicaid, arguably the provisons are ambiguous so the Secretary's interpretation should have been given Chevron deference.

In essence, the Petitioners are petitioning this court on their interpretation of section 1396a(n) as it existed pre-BBA. Whatever section 4714 did, it affirmed Congress' policy that states do not have to pay providers of Part A and B services to QMBs at the

Medicare rate. Accordingly, the Petitioners are contending for an interpretation of section 1396a(n) and a basic policy position about reimbursement that Congress is unwilling to support.

California is correct regarding its interpretation of its reimbursement duty under Medicaid. Medicaid is the payor of last resort. The statutory scheme is that all other sources of payment must be exhausted before the Medicaid program is available for payment. California has been consistent in this scheme. Until Judge Letts issued his order in 1996, California's Medicaid program did not reimburse providers more than the Medicaid rate for QMBs.

Part A was different but only because a difficulty existed in determining for hospital services what was the Medicaid rate in relation to the Medicare rate. Once that Medicaid rate was established in 1994 by California's Medicaid agency, Part A was applied consistently with reimbursement under Part B.

It is clear that Congress intended in 1988 to mandate the states to include QMBs as part of the Medicaid program. Few states had voluntarily joined - unquestionably owing to the financial burden that joinder would impose. In that light, without a clear expression of intent, it does not make sense for Congress to both mandate QMBs into the Medicaid program and to burden the states with additional financial costs - which they had been unwilling to assume - without a clear expression that the providers would benefit from this change in the law.

To the contrary, Congress left section 1396a(n) untouched in 1988 in order to preserve the states

flexibility in responding to this mandatory addition to the Medicaid program. As we pointed out above, Medicaid is a jointly funded federal-state program. As a joint spending program, "if Congress intends to impose a condition on the grant of federal moneys" to the states, "it must do so unambiguously." Pennhurst State School & Hosp. v. Halderman, 451 U.S. 1, 17 (1981) (citations omitted). Only if courts "insist[] that Congress speak with a clear voice" can the states "exercise their choice knowingly, cognizant of the consequences of their participation." (*Id.*) Although California believes Congress was clear in the past regarding its reimbursement duty to providers regarding section 1396a(n), at the minimum the provision is ambiguous and should not be interpreted against her under Pennhurst. In light of the Secretary's support for California's position, the Secretary's interpretation should be conclusive under Chevron U.S.A. Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984).

The circuits could reject the Secretary's construction of the statute only if they were able to conclude that "Congress has directly spoken to the precise question at issue"; otherwise, "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." Chevron, 467 U.S. at 842-43 (1984) (emphasis supplied) (footnote omitted). The Kozlowski majority acknowledged that the Medicaid and Medicare acts were "among the most impenetrable texts within human experience" and provide "dense reading of the most tortuous kind." 42 F.3d at 1444. In this "'complex and highly technical regulatory program,'" deference "is all

the more warranted." Thomas Jefferson University v. Shalala, 512 U.S. 704, 710 (1994) (citation omitted).

Section 1396a(a)(10)(E) of Title 42 provides that a state plan "must" make Medicaid funds available for medical cost-sharing on behalf of QMBs. "Cost-sharing" is separately defined as including Part A deductibles and coinsurance. 42 U.S.C. 1396d(p)(3). The Petitioners read Section 1396a(a)(10)(E) and Section 1396d(p)(3) together as making it mandatory on the states to pay 100% of all reasonable charges for QMBs.

Yet if the Petitioners are correct in their reading, Section 1396a(n) -- which is entitled "Payment Amounts" and permits (but does not require) states to make payments in excess of the Medicaid ceiling -- would be entirely unnecessary, even though this section was enacted at the very same time, and in the same piece of legislation that created Section 1396a(a)(10(E).

Apart from this anomaly, the Petitioners' statutory reading is flawed. It is argued that, having used the word "must" in §1396a(a)(10)(E), Congress made mandatory the obligation on states to pay cost-sharing. The statutory language the Petitioners rely upon, however, does not mandate payment of coinsurance and deductibles in full, as the Petitioners would have it. Section 1396d(p)(3) is not addressed to the subject of payment amounts. It merely states that in certain circumstances the state is obliged to pay premiums and deductibles and coinsurance, without specifying whether the costs are to be paid in full, or are subject to the standard Medicaid limits.

Because Section 1396a(a)(10)(E) does not specify the amount of money a state is obliged to pay as coinsurance for QMBs and dual eligible, the Court must look elsewhere in the statute. Finding the relevant section is not hard: 42 U.S.C. 1396a(n), which was enacted in the same piece of legislation as Section 1396a(a)(10)(E), is entitled "Payment Amounts," and gives the states leave to limit reimbursement of coinsurance and deductibles to the ceiling set by Medicaid -- or in the alternative to pay the full 100%, as the state wishes. Section 1396a(n) is the answer to the question posed by this lawsuit -- not Section 1396a(a)(10)(E).

The two provisions may be reconciled by reading Section 1396a(a)(10)(E) to require that funds be available for coinsurance and deductibles only to the extent that a Medicaid plan under Section 1396a(n) provides for payments in excess of Medicare payments.

2. No review is appropriate because the circuits are not in confict over the merits of this case.

Rule 10.1(a) sets forth that reason for granting a petition for certiorari might be "[w]hen a United States court of appeals has rendered a decision in conflict with the decision of another United States court of appeals on the same matter." The Petitioners' fundamental ground for requesting certiorari from this court is that there is a conflict among the circuits because the court of appeals in Paramount and Beverly reached different conclusions than Kozlowski, Haynes, Snider, and Perales. This argument is fallacious. When the four cases were decided, the courts did not have the clarification provided by Congress. We do not know

what result these courts would have reached with this additional factor in mind. In any event, the two circuits post-section 4714 are consistent in holding that, when taken with the clarification from Congress, the better decision was that section 1396a(n) did authorize the states to make payments to providers at an amount less than the Medicare payment rate. For this reason, there is no conflict which warrants review by this court.

3. The "clarification" cannot be considered bogus by the argument that Congress shold have made the "clarification" as the Petitioners would have Congress do it.

The Petitioners argue strongly that the "clarification" of Congressional intent is bogus - that the Paramount and Beverly courts should have found that Congress did not clarify the law - it substantially changed the law. It is clear that Congress did intend to clarify the law. The title to section 4714(a) states that the amendment is a "clarification." Section 4714(c) states that the amendment relates back to "items and services furnished before [the date of the enactment of this Act] if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of enactment of this Act." The House Committee report recognizes a reimbursement gap between what the states and Medicare pays and expressly states that section 4714 "clarifies that state Medicaid program may limit Medicare cost-sharing to amounts that, within the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB."

The Petitioners press several arguments, in the face of Congress' explicit statement of clarification, to demonstrate that no clarification exists. They argue section 1396a(n) is unchanged in text as section 1396a(n)(1), that the cap is placed in a new subsection 1396a(n)(2), that three new provisions were enacted (i.e., that Medicare is "payment in full," that providers have no recourse against the beneficiaries, and that a third party may be liable for the payment gap) and that a clarification does not need an "effective" date. They also argue that it is probative that the "clarification" appears in a budget measure.

Petitioners' arguments beg the question. Congress' clarification tracks the interpretation California and the Secretary have taken regarding section 1396a(n). If Congress had not expressly stated it was clarifying the law, Petitioners' arguments might have some merit. Petitioners argument is that for Congress to have a true clarification it must legislate narrowly on the issue. Presumptively, if Congress had only enacted section 1396a(n)(2) and called it a clarification, Petitioners would have no complaint. The fact that Congress added provisions to make its original intent more workable or clear should not detract from its attempt to clarify the law.

The fact that section 4714 was enacted in a budget provision makes sense. The dispute is not over the coverage of benefits to poor people. The dispute is between providers, and the states and the federal government over the rates of reimbursement. The need for an effective date is reasonable. In the Snider, Perales, Haynes, and Kozlowski circuits, the providers are no longer to be paid at the Medicare rate. Congress wisely limited the impact of the clarification to

circuits which had pending lawsuits, not those in which the rights of the providers had become vested by virtue of a final judicial decision.

4. There is no "conflict" in this Court's decisions over the issue of the proper deference to be given a Congress' effort to clarify the law.

The Petitioners argue that a conflict exists between this Court's rule regarding the deference to be given Congressional enactments which purport to clarify the effect of prior law. In fact, that conflict does not exist or, if it does, it is hardly sufficient to justify this Court granting writs of certiorari to review these cases.

In Red Lion Broadcasting Co. v. FCC, 395 U.S. 381 (1968) this Court was confronted with a challenge by a licensee of the Federal Communications Commission to the "fairness doctrine." The FCC had interpreted the underlying statute by regulation which set forth the rule. Thirty years later Congress enacted a statement of the FCC rule under circumstances which the Court found to be a clarification of existing law. In such a case, this Court held:

> "Subsequent legislation declaring the intent of an earlier statute is entitled to great weight in statutory construction. And here this principle is given special force by the equally venerable principle that the construction of a statute by those charged with this execution should be followed unless there are compelling indications that it is wrong, especially when Congress has refused to alter the administration construction. Here, the

> Congress has not just kept its silence by refusing to overturn the administrative construction, but has ratified it with positive legislation. (Id. at 380-382 [footnotes omitted].)

This announcement of statutory construction in Red Lion Broadcasting fits the facts of these cases like a glove. The Secretary held to a long standing position that the states did not have to pay the full cost sharing amounts. Congress never altered the Secretary's interpretation. Later, Congress ratified that administrative construction with positive legislation by enacting section 4714. This Court in Red Lion Broadcasting pointed out that this principle of statutory construction was "venerable." (Id. at 381, n. 8.)

In Loving v. U.S., 517 U.S. 748, 116 S.Ct. 1737 (1996) this court repeated this "venerable" principle with approval but in a fact situation less applicable to the facts before this court.

The Petitioners create a false dilemma - that a conflict exists between two lines of authority of this Court and that only a resolution of that conflict in these cases can "clarify" the rule for subsequent cases. In order to advance that argument, the Petitioners contend that the line of cases exemplified by Public Employees Ret. System v. Betts, 492 U.S. 158 (1989) ("Betts") creates this conflict.

In Betts a disability retiree invoked a prohibition against age based discrimination under ERISA against a public employees retirement system which had insured her pursuant to a plan that pre-dated the discrimination provision. The critical question

was whether the plan was a "subterfuge" to avoid the prohibition. The retiree argued that certain statements by a house committee and by influential members of the Congress demonstrated its interpretation of "subterfuge" was appropriate.

> This Court disagreed, commenting:
> "We have observed on more than one occasion that the interpretation given by one Congress (or a committee or Member thereof) to an earlier statute is of little assistance in discerning the meaning of that statute. (citations omitted) (Id. at 168.)

In Betts and the others cited by Petitioners, Congress does not act as a whole in enacting a specific clarification of a statute. It makes sense that whether Congress is ambivalent whether a clarification is intended (Gwaltney v. Chesapeake Bay Foundation, 484 U.S. 49, 63 n.4 (1988); ; South Dakota v. Yankton Sioux Tribe -- U.S.--, 118 S.Ct. 789 (1998)) when a house committee or a member of Congress purports to speak about past Congressional intent (Mackey v. Lanier Collection Agency & Serv., 486 U.S. 825, 839-840), that "little" assistance is rendered. However, when Congress amends the substantive statute in such a fashion that it unequivocally signals that it is clarifying what has been a statute subject to different interpretations, it makes sense that this Court should invoke that "venerable" rule of statutory construction that the judiciary should give Congress' enactment "heavy weight."

In summary, then, there is really no conflict between the two principles.

5. Beverly and Paramount determined that the statutory role given to section 1396a(n) scheme was ambiguous and therefore weight should be given to the clarification by Congress.

As variation on the Petitioners' attempt to see a conflict where none exists, the Petitioners argue that the Ninth Circuit and the court in Paramount should have first done a detailed analysis of the statutory scheme to demonstrate there was an ambiguity for which clarification was necessary (e.g., "the Ninth Circuit's decision failed to independently determine for itself either the meaning and intent of the 1986 QMB amendments or whether § 4714...was in any way a tenable reading of the legislation." (California Ambulance Ass'n at 21.)

What the Ninth Circuit did was to point out that various opinions had used different approaches to the proper interpretation of the statute, that the proper intent was not clear, and that section 1396a(n) was a baffling statutory provision. The Petitioners can not concede it was unclear how section 1396a(n) fit into Congress' scheme for providing benefits to QMBs. Once they make that concession, Chevron kicks in and they are lost. In any event, the Court did conclude that section 4714 was a tenable clarification of section 1396a(n) and that deference should be shown to Congress.

In Paramount, the court reached the same conclusion. Both circuit opinions must be read as agreeing that section 1396a(n) is puzzling and therefore they fulfilled whatever responsibility the Petitioners would impose upon them regarding the interpretation of

section 1396a(n). Consequently, the Petitioners do not establish that the circuit opinions lacked any condition precedent to their deference to Congress' clarification of the controversy.

6. Klein is not a ground for review under the facts of these actions.

The Petitioners' citation of United States v. Klein, 80 U.S. 128 (1872) as a basis for review is mystifying. The argument appears to be that Klein is relevant because section 4714 represents a "rule of decision" passed by Congress designed to intrude into the judicial province. The Petitioners then raise the specter of an Article III dilemma allegedly represented by section 4714 so that this Court will have the "...opportunity to provide direction to the lower courts by clarifying the scope of Klein." (Beverly pet. at 23.)

The Beverly decision does not mention the issue. Judge Posner talks about it in Paramount but never thought it sufficiently important to resolve the issue. That is easy to see why. In Klein Congress specifically attempted to change the law retroactively to avoid a decision of this Court, intruding into the powers reserved to the judiciary by Article III. Section 4714 does not represent a rule of decision. It is a clarification of the law that was in dispute. The rule of this Court is that when Congress provides clarification the judiciary gives great or little weight to that clarification depending upon the circumstances of the clarification. The Klein issue is simply not presented by this action.

The Petitioners harp on the argument that Congress enacted section 4714 in order to "decide the

controversy in [its] favor," quoting United States v. Sioux Nation, 448 U.S. 371, 404, 100 S. Ct. 2716, 2735-36, 65 L.Ed 2d 844 (1980) as somehow relevant. Unquestionably, Congress had the authority to decide the controversy in its favor prospectively by amending the statute. (Plant v. Spendthrift Farm, Inc, 514 U.S. 211, 218 (1995). In that sense, Congress decided the controversy in favor of the Secretary and the state. In Sioux Nation, this Court discussed Klein but did not reach the Klein issue. Accordingly, it is hard to see how Sioux Nation adds anything to the Petitioners' case. Moreover, when Congress enacts a clarification, by the nature of a clarification Congress is attempting to direct the outcome in a fashion Congress perceives to be in its "favor."

Finally, Congress did not attempt to impose a rule of decision upon the four circuits in which the courts - erroneously - held against the Secretary. The scope of its clarification only went to those circuits in which no provider had received any vested right by a final judicial decision. Accordingly, Congress never crossed over the separation of powers between the legislature and the judiciary.

7. No provider in California was promised payment by the state for crossover claims at 100% of what Medicare Providers charge.

This issue can not be reached by this Court unless it resolves the underlying dispute whether section 1396a(n) - pre-BBA - provided flexibility to the states to set the payment levels for Part A and Part B services below the Medicare charge levels for crossover claims.

In any event, from the perspective of California, this issue is contrived.

The Petitioners argue that "It is fundamentally unfair and constitutionally infirm for Congress to tell a provider who has been promised $100 to provide a service, that after providing the service, the rate has been changed after the fact to $80." (California Ambulance Ass'n at 30.)[2] No provider in California was under the illusion that it was promised $100 and then paid $80. Under Samuel, since 1983 all providers were on notice that California paid the Medicaid level of payment - not the Medicare level of what the providers charged.

In California, the relationship between the providers and California is a contract. (California Medical Assn. v. Lackner, 117 Cal.App. 3d 552, 560 (1981).) In California, "A statute fixing government payments may amount to an offer which, when accepted by performance, culminates in a contract between the government and the offeree." (internal quotation marks removed.) (Ibid.) Under this theory, Lackner held that the regulations - which are authorized by statute - of the Department constituted an offer and the providers acceptance of that offer - by providing services - constituted an implied contract. (Id. at 561.)

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2. The amicus brief filed by the American Medical Association argues that 4714 is unconstitutional under Eastern Enterprises v. Apfel, -- U.S. --, 118 S.Ct. 2131 (1998), contending that "the law's effect depends solely upon the confiscation of [physician's vested rights to payment under the prior statutory scheme]." (AMA Brief at 11.) Yet, in California the reasonable expectation of physicians was that they would be paid at the Medicaid rate. Consequently, Eastern Enterprises - aside from the fact the facts of the case have no resemblance to those of this action - does not apply.

Welfare and Institutions Code section 14109.5 clearly expressed the California policy - offer if you will - to providers that they would not be reimbursed at the rates they charged pursuant to Medicare for crossover claims. Consequently, no California provider of Part A or Part B services was promised $100 as the Petitioners claim.

CONCLUSION

The petitions should be denied. "[Section 1396a(n)] has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification." Beverly at 1266).

Dated: August 28, 1998

Respectfully submitted,

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APPENDIX A

§ 14109. Determination of medical needs; inclusion of cost of deductibles or cost sharing charge

In determining the medical needs of any person eligible under this chapter, and the amount of health care such person is entitled to receive, the department shall include the cost of any deductibles or, cost sharing or similar charge imposed in connection with benefits to which such person may be entitled under the federal program of health insurance for the aged and disabled, except that for those individuals 65 years of age or over, who prior to July 1, 1973, were ineligible under the federal program of health insurance for the aged, the director may include such costs.

§ 14109.5. (1982) Limitation on reimbursement rate notwithstanding inclusion of cost of deductibles or cost sharing charge; change orders, expeditious implementation

Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter.

The fiscal intermediary shall expedite the implementation of any change order resulting only from this section. The department shall provide sufficient funding for any such change order to enable the fiscal intermediary to implement such change order expeditiously and to not have to divert staff or other resources from existing contract tasks, including but not limited to those resources dedicated to the implementation of all other change orders.

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FILED
SEP 2 1998
OFFICE OF THE CLERK
SUPREME COURT, U.S.

Nos. 97-1947, 97-1949 and 97-2079

In the Supreme Court of the United States

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QUESTION PRESENTED

Whether Section 4714 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 509-511, clarifies the States' payment obligations to providers of medical services to qualified Medicare beneficiaries, set forth in the prior version of the Medicaid Act, 42 U.S.C. 1396a(n) (1994 & Supp. II 1996).

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OPINIONS BELOW

This brief is submitted by the Secretary of Health and Human Services in opposition to three petitions for

a writ of certiorari that seek review of the same judgment of the United States Court of Appeals for Ninth Circuit. The Secretary was named as a defendant in No. 97-1949 and No. 97-2079, but participated only as *amicus curiae* in No. 97-1947. The opinion of the court of appeals (97-1947 Pet. App. 1a-23a) is reported at 132 F.3d 1259. The opinions of the district court (97-1947 Pet. App. 24a-29a; 97-1949 Pet. App. 23a-31a; 97-2079 Pet. App. 26-28) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on December 2, 1997. 97-1947 Pet. App. 30a-32a. A petition for rehearing was denied on March 3, 1998. The petitions for a writ of certiorari were filed on June 1, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. Medicare is a federal program that provides for medical coverage for individuals who are disabled or at least 65 years of age, and who meet certain other eligibility requirements. Those persons are automatically enrolled in Part A of the Medicare program, a federally funded hospital insurance program. See 42 U.S.C. 1395 *et seq.* (1994 & Supp. II 1996). A provider of medical services to beneficiaries under Medicare Part A receives a significant portion of its fee from the federal government, which pays the provider from the Federal Hospital Insurance Trust Fund established by 42 U.S.C. 1395i.[1] The beneficiary is responsible for coin-

[1] We use the term "provider" in this brief "in its colloquial sense rather than in its technical Medicare senses," as did the Seventh Circuit in the related case of *Paramount Health Systems,*

surance payments and deductible amounts. See 42 U.S.C. 1395e.

Persons who are covered by Medicare Part A (and certain other persons) may also purchase supplementary insurance for additional medical services under Part B of the Medicare program by paying a monthly premium to the Federal Supplementary Medical Insurance Trust Fund, which is established by 42 U.S.C. 1395t. A provider of medical services to beneficiaries under Medicare Part B receives a portion of its fee, typically 80% of the applicable fee schedule amount, from the Supplementary Medical Insurance Trust Fund. The beneficiaries of Part B services pay (in addition to premiums) coinsurance, copayments and deductible amounts. 42 U.S.C. 1395*l*(a)(1) and (b), 1395r.

b. The Medicaid program is a cooperative federal-state public assistance program that provides federal financial assistance (*i.e.*, federal matching funds) to States that elect to pay for medical services on behalf of certain needy individuals. See 42 U.S.C. 1396 *et seq.* (1994 & Supp. II 1996); *Harris* v. *McRae*, 448 U.S. 297, 301 (1980).[2] The Medicaid Act gives participating States discretion in setting the rates they will pay providers, within boundaries set by federal law. See 42 U.S.C. 1396a(a)(30). A participating State must submit a state plan, setting forth the fee schedule or methodology that the State will use in reimbursing providers, to the Secretary of Health and Human Services for ap-

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Inc. v. *Wright*, 138 F.3d 706, 706 (1998), petition for cert. pending, No. 97-2029.

[2] Federal financial participation is calculated according to a statutory formula that pays, at a minimum, 50% of the State's costs. 42 U.S.C. 1396b(a)(1), 1396d(b).

proval. See 42 U.S.C. 1396a(b). Providers generally must accept a State's payment for services covered under the Medicaid plan as payment in full, and may not seek to collect other than nominal payments for such services from the beneficiary or elsewhere. See 42 U.S.C. 1396*o*.

c. The Medicare and Medicaid Acts overlap in coverage for needy persons who are also elderly or disabled. Such individuals are often entitled to participate in Medicare Part A, but they may not be able to pay either the premiums needed to enroll in Medicare Part B or the coinsurance, copayments and deductibles for which they would be responsible under Parts A and B. To address that problem, Congress has required States participating in the Medicaid program to enter "buy-in" agreements with the Secretary of Health and Human Services. Under a buy-in agreement, the States use Medicaid funds to pay the Medicare Part B premiums on behalf of individuals who are eligible for both Medicare and Medicaid, and certain other persons who are eligible for Medicare but do not meet the general eligibility criteria for Medicaid coverage. See 42 U.S.C. 1395v, 1396d(a). As a result, the State's Medicaid program pays the Medicare premium, rather than the full medical expenses, of the elderly or disabled Medicaid-eligible persons, and these persons are then enrolled in the Medicare B program; the cost of their medical care thus is shifted in large part from the States' Medicaid programs to the federal government under Medicare.

Initially, the only persons eligible for this Medicare "cost-sharing" were those who met the qualifications for both Medicare and Medicaid services ("dual eligibles"). In 1986, Congress extended the class of persons eligible for the buy-in program to include individuals who have incomes below the federal poverty line but

who do not meet the income and assets qualifications for Medicaid eligibility. See Omnibus Budget Reconciliation Act of 1986 (OBRA), Pub. L. No. 99-509, § 9403, 100 Stat. 2053-2054. Members of this new class of individuals eligible for the buy-in program were called Qualified Medicare Beneficiaries, or "QMBs." See OBRA § 9403(b), 100 Stat. 2053. In 1988, Congress required States' Medicaid plans to buy-in to Medicare Part B for these individuals (as well as the "dual eligibles" who had been covered by buy-in agreements before 1986). Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748. Congress also redefined the statutory term "qualified medicare beneficiary" to include both the former group of QMBs (a group often called "pure" QMBs) and dual eligibles. Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8434, 102 Stat. 3805; see 42 U.S.C. 1396d(p)(1).

d. As noted above, Medicare Part B typically leaves individuals responsible for copayments, coinsurance, and deductible amounts. The elderly poor and disabled poor who are enrolled in Part B under the buy-in process (the QMBs) are often unable to meet such expenses. Congress has therefore required participating States' Medicaid plans to contribute towards those expenses on behalf of QMBs. See 42 U.S.C. 1396a(a)(10)(E)(i), 1396d(p)(3). The *amount* owed by the States to providers of medical services for those expenses is the subject of this dispute.

The Section of the Medicaid Act that governs the "contents" of state plans requires that a state plan for medical assistance must "provide * * * for making medical assistance [*i.e.*, Medicaid funds] available for medicare cost-sharing" for QMBs. 42 U.S.C. 1396a(a)(10)(E)(i). The Medicaid Act defines "medicare

cost-sharing" to include the specified premiums, coinsurance, copayments and deductibles owed under Medicare. 42 U.S.C. 1396d(p)(3).

Although Section 1396a(a)(10)(E)(i) thus requires States to make medical assistance available for Medicare cost-sharing for QMBs, that Section does not address the *amount* of cost-sharing to be paid by the States. A different Section, titled "Payment Amounts," addresses that issue. Before 1997, that Section provided:

> In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan *may provide payment* in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter [*i.e.*, Medicare] with respect to the service or item *exceeding the amount that is otherwise payable under the State plan* for the item or service for eligible individuals who are not qualified medicare beneficiaries.

42 U.S.C. 1396a(n) (emphasis added).

The Secretary of Health and Human Services read Section 1396a(n) to permit States to limit their cost-sharing payments to the amount (if any) by which the State's Medicaid rate for the service provided exceeded the amount that Medicare has paid, and has approved state plans that impose such a cap.[3] In essence, the Secretary permitted the States to limit their payments to the amount that they would have paid for QMBs'

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[3] It is undisputed that States must pay Part B premiums in full.

medical services under the Medicaid program, had they not been enrolled in Medicare, less the federal contribution made under Medicare. Providers of medical services argued, however, that the Medicaid and Medicare statutes required the States to pay those expenses in full. Four courts of appeals rejected the Secretary's construction of the Medicaid Act and ruled that the Act required States to pay the cost sharing in full. See *Rehabilitation Ass'n of Virginia, Inc.* v. *Kozlowski*, 42 F.3d 1444 (4th Cir. 1994), cert. denied, 516 U.S. 811 (1995) (*Kozlowski*); *Haynes Ambulance Serv., Inc.* v. *State of Alabama*, 36 F.3d 1074 (11th Cir. 1994) (per curiam) (*Haynes*); *Pennsylvania Med. Soc'y* v. *Snider*, 29 F.3d 886 (3d Cir. 1994) (*Snider*); *New York City Health & Hosps. Corp.* v. *Perales*, 954 F.2d 854 (2d Cir.), cert. denied, 506 U.S. 972 (1992) (*Perales*).[4]

Although those appellate courts each rejected the Secretary's construction of Section 1396a(n), they disagreed among themselves as to the precise rationale for the result that they had reached, see 97-1947 Pet. App. 20a, there were dissents from two of the appellate decisions, see *Kozlowski*, 42 F.3d at 1462-1472 (Niemeyer, J., dissenting); *Perales*, 954 F.2d at 863-869 (Cardamone, J., dissenting), and two district courts upheld the Secretary's construction even after *Kozlowski*, the last of the appellate decisions, was issued. See *Dameron Physicians Med. Group* v. *Shalala*, 961 F. Supp. 1326

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[4] The relevant state authorities filed petitions for a writ of certiorari in *Kozlowski* and *Perales*. In the government's responses to the certiorari petitions in those cases, we argued that, although we believed that the courts of appeals' decisions were wrong, the absence of a conflict among the circuits counseled against further review. See 94-1912 Gov't Br. in Opp. 7-12 (July 1995); 92-315 Gov't Br. in Opp. 7-9 (Oct. 1992).

(N.D. Cal. 1997); *Kulkarni* v. *Leean*, No. 96-C-884-S, 1997 WL 527674 (W.D. Wis. June 23, 1997).

e. In 1997, Congress enacted Section 4714 of the Balanced Budget Act, which amended 42 U.S.C. 1396a(n). Section 4714(a) is titled "Clarification Regarding State Liability For Medicare Cost-Sharing." See Balanced Budget Act of 1997 (BBA or 1997 Act), § 4714(a), Pub. L. No. 105-33, 111 Stat. 509. It provides that, in carrying out its cost-sharing obligations under Section 1396a(n), "a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that" such payments would exceed "the payment amount that would otherwise be made under the State [Medicaid] plan." 42 U.S.C. 1396a(n)(1)(B). Section 4714(a) thus expressly continues in effect the Secretary's longstanding position under the applicable Medicaid provisions as they existed before the enactment of the 1997 Act. As its title states, Section 4714(a) was enacted to "[c]larif[y] that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB." H.R. Conf. Rep. No. 217, 105th Cong., 2d Sess. 870-871 (1997).

Congress also provided that the clarification in Section 4714(a) would apply, not only prospectively, but also to payments for items and services rendered before the effective date of the clarification, if such payments were the subject of any lawsuit pending as of, or initiated after, the date of enactment. See BBA § 4714(c), 111 Stat. 511; 97-1947 Pet. App. 38a. The amendment does not apply, however, to payments that were the subject of cases challenging the Secretary's

interpretation of the Medicaid Act prior to passage of the 1997 Act that had been litigated to final judgment.

2. a. Before the 1997 amendments were passed, petitioners, who provide medical services to QMBs in California, brought these actions to compel the California Medicaid program to pay cost-sharing for QMBs in full. Petitioners challenged California's policy, reflected in state regulations and in a state plan approved by the Secretary, of limiting cost-sharing payments to the amount (if any) by which the California Medicaid rate exceeds what Medicare pays. Petitioners argued, *inter alia*, that the Medicaid Act required the State to pay cost-sharing in full.

The same district judge presided in each case. The district court granted petitioners' motions for summary judgment, following the Second, Third, and Eleventh Circuit decisions that had rejected the Secretary's construction of the Medicaid Act, and also adopting the "similar reasoning" of the Fourth Circuit, except in part. See 97-2079 Pet. App. 26-28; see also 97-1947 Pet. App. 27a-29a; 97-1949 Pet. App. 20a-23a.

b. The Secretary appealed the district court's decisions. After briefing on appeal was complete, Congress enacted Section 4714 of the Balanced Budget Act of 1997. In supplemental briefing, petitioners urged that Section 4714 changed rather than clarified the prior payment rules, and that the retroactive application of the new payment rules was unconstitutional.[5] The court of appeals reversed. It held that Section 4714 clarified the law, and that it therefore has no retro-

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[5] Petitioners did not dispute that the new law could be applied prospectively. See 97-1947 Pet. App. 18a.

active effect that might be called into constitutional question. 97-1947 Pet. App. 1a-23a.[6]

The court emphasized that "Congress expressly (and formally) stated as its intention that the new provision in [BBA] § 4714 was a 'clarification' of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic * * * that congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight." 97-1947 Pet. App. 18a. The court remarked that some of this Court's decisions have "question[ed] the competence of a later Congress to opine on the intended meaning of an earlier statute," but it observed that those decisions "involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments." *Ibid.* "By contrast, here Congress has formally declared [BBA] § 4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports." *Id.* at 19a.

The court rejected petitioners' argument that Section 4714(a) could not be a clarification of the law because it effected a substantial change in the law. That argument, the court held, failed to take account of the differences in rationales among the decisions construing Section 1396a(n); it also ignored the fact that "any quality of crystal clarity is uniformly recognized as

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[6] The court of appeals rejected petitioners' argument that Section 4714 does not apply to these cases because they were already on appeal when the Balanced Budget Act of 1997 was enacted, and therefore the cases were not "pending" within the meaning of Section 4714(c). See 97-1947 Pet. App. 16a-17a. That argument has not been renewed in this Court.

totally absent from the Medicaid and Medicare statutes," which have been characterized as "among the most completely impenetrable texts within human experience." 97-1947 Pet. App. 19a-20a. The court found Section 1396a(n) itself to be "a superb example of the baffling nature of the statute." *Id.* at 20a. "Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference," and petitioners' arguments that the law changed rather than clarified the law "incorrectly presume a clearly established meaning for Section 1396a(n)—something that simply did not exist before [BBA] § 4714 was adopted." *Id.* at 20a-21a.

The court therefore "honor[ed]" Congress's express description of Section 4714(a) as a clarification of the law. 97-1947 Pet. App. 21a. That decision, observed the court, "moots all of [petitioners'] constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of [BBA] § 4714." *Ibid.*

ARGUMENT

The court of appeals correctly concluded that Section 4714(a) of the Balanced Budget Act of 1997 clarified rather than changed existing law governing States' obligations under their Medicaid plans to pay for Medicare cost-sharing, and therefore raises no potential constitutional questions of retroactivity. That decision does not conflict with any decision of any other court of appeals, and it presents no issue of continuing importance. Furthermore, even if Section 4714(a) changed the law, petitioners' constitutional claims

would lack merit. Further review is therefore not warranted.

1. In enacting Section 4714(a), Congress ratified the Secretary's longstanding position that a State may limit its cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare pays for a given service. Because the Secretary's construction of prior law was correct and reasonable, Section 4714 did not change the law and therefore raises no questions of retroactivity.

"The power of an administrative agency to administer a congressionally created * * * program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress." *Morton* v. *Ruiz*, 415 U.S. 199, 231 (1974). Accordingly, as this Court held in *Chevron U.S.A. Inc.* v. *National Resources Defense Council, Inc.*, 467 U.S. 837 (1984), where Congress has not expressed its intention on a precise question at issue, courts should defer to a reasonable interpretation of the statute in question by the agency charged with administering the program under that statute. *Id.* at 844.

The Secretary's position on the extent of the States' cost-sharing obligations was reasonable. Section 1396a(a)(10)(E)(i) imposed upon the States the obligation to provide "for making medical assistance available for cost-sharing * * * for qualified medicare beneficiaries." That provision, however, did not specify any particular *amount* that States must make available for cost-sharing. Section 1396a(n), titled "Payment Amounts," did address the issue of amount, and provided that a State "may" pay cost-sharing even if the sum of the federal Medicare payment and the state payment exceeded the amount otherwise payable under

the state Medicaid plan to eligible individuals who are not QMBs. The Secretary reasonably construed Section 1396a(n) to permit, but not to require, States to pay cost-sharing in excess of the State's Medicaid rate. The Secretary's construction flowed naturally from the language of the Medicaid Act, since there was no other apparent reason for Congress to have provided in the Medicaid Act that a State "may" pay more cost-sharing than the difference between the State's Medicaid rate and the amount that Medicare pays.

Petitioners emphasize that three of the four courts of appeals that rejected the Secretary's construction of Section 1396a(n) read that provision as providing only that providers (or States) would not be penalized for accepting (or making) payments that, with the Medicare payment, exceeded the Medicaid rate. See *Perales*, 954 F.2d at 859; *Snider*, 29 F.3d at 895; *Haynes*, 36 F.3d at 1076. As the Seventh Circuit recently explained, however, those readings of the Medicaid Act are "undermined by the fact that if [as petitioners argue] * * * the statute *clearly* entitle[d] [petitioners] to reimbursement at Medicare rates, * * * the state [or provider] could hardly be penalized for such reimbursement. That would be penalizing it for complying with the statute." *Paramount Health Sys.* v. *Wright*, 138 F.3d 706, 709 (7th Cir. 1998), petition for cert. pending, No. 97-2029.[7] As Judge Niemeyer pointed out in his dissent in *Kozlowski*, "[i]t is utterly implausible * * * to believe that Congress would create a new section in the Act solely to acknowledge that it is permissible for states to do what

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[7] The petition pending in *Paramount* raises the same question as that presented here, and our response to that petition is being filed contemporaneously with this brief.

Congress *requires* them to do in other sections." 42 F.3d at 1469.

The Secretary's construction, moreover, comports with the purpose of the buy-in provisions, which is to relieve the States from the financial obligations that they would have to shoulder under their Medicaid plans if QMBs were not able to participate in the Medicare Part B program. Specifically, the Secretary's construction recognizes that, if the States did not buy QMBs into Medicare, the States would be required to pay for the medical care of at least those QMBs who are eligible for Medicaid, at whatever their Medicaid rates would allow. It is therefore reasonable to conclude that the States should not have to pay for medical services at a rate that is higher than the rate at which their own Medicaid plans would otherwise have required payment.

The legislative development of the provisions at issue further supports the reasonableness of the Secretary's construction. When Congress made buy-in coverage of all QMBs mandatory in 1988, the House Report accompanying the legislation specifically stated that States would not be required to make payments in excess of their Medicaid ceilings. See H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988). In 1989, Congress again amended the QMB provisions to "codif[y] the current practice with respect to dual eligibles and extend[] it to qualified Medicare beneficiaries." H.R. Rep. No. 247, 101st Cong., 1st Sess. 429 (1989). It did so, *inter alia*, by requiring physicians to accept assignments of claims from QMBs for the specific purpose of preventing physicians from exceeding the Medicaid ceilings by billing QMB patients directly for such additional amounts. *Ibid.*; see 42 U.S.C. 1395w-4(g)(3); Omnibus Budget Reconciliation Act of 1989, Pub. L. No.

101-239, § 6102(a), 103 Stat. 2169. Thus, Congress has treated QMBs principally as persons eligible for Medicaid benefits, but whose medical expenses are paid in large part by Medicare.

Even if the Medicaid Act is less than crystal clear on the extent of state Medicaid plans' obligations to pay for cost-sharing, it cannot be reasonably contended that the law was so clear and firmly settled against the Secretary's construction that Section 4714(a) must be viewed as a change in the law, despite Congress's express designation of it as a clarification. This Court, of course, had never considered the statutory question at issue. Although four circuits had rejected the Secretary's construction, they had not read the statutes in the same way, and neither the Seventh Circuit nor the Ninth Circuit—where the constitutional challenges to Section 4714(a) have been brought—addressed the statutory question. Two district courts had disagreed with the four circuits' construction of the Medicaid Act and had upheld the Secretary's position.

At a minimum, therefore, the Medicaid Act was "a hopeless muddle so far as [QMB] reimbursement [was] concerned." *Paramount*, 138 F.3d at 711; see also *Kozlowski*, 42 F.3d at 1450 (describing provisions governing Medicaid and Medicare financing as "among the most impenetrable texts within human experience"); 97-1947 Pet. App. 19a-20a (decision below; same). "[T]he fact that well-intentioned and intelligent experts at legal exegesis have arrived at three or four seemingly plausible readings of a particular text may be the best evidence that this interpretive puzzle has no definitive answer." *Kozlowski*, 42 F.3d at 1462-1463 (Niemeyer, J., dissenting). Under these circumstances, Congress's designation of Section 4714(a) as a clarifi-

cation, rather than a change, of the States' obligations under the Medicaid Act, deserves deference.

2. Petitioners urge the Court to grant certiorari to clarify how much weight should be given to a congressional interpretation of prior law, as reflected in a statutory amendment. Petitioners argue that there is tension in this Court's precedents addressing the issue. See 97-1947 Pet. 12-17; 97-1949 Pet. 18-21; 97-2079 Pet. 18-23. That issue is not presented in this case, however, because the Secretary reasonably construed the prior law to arrive at the result that Congress subsequently directed in Section 4714(a). Accordingly, the question of the weight owed to Congress's view, as expressed in Section 4714(a), that the new statute is a "clarification," is academic. At the least, this Court could not reject Congress's view that Section 4714 clarifies prior law without first analyzing the complex and now-superseded pre-1997 framework governing state payment of cost-sharing for QMBs, and determining whether the Secretary's construction of those provisions would have been owed deference under *Chevron*. That antecedent question of statutory interpretation, however, is of no continuing importance.

Moreover, the asserted tension in this Court's decisions is illusory. This Court has stated that express congressional declarations in *legislation* about the meaning of an earlier statute are given great weight, but that statements in "subsequent legislative history" such as committee reports about the meaning of earlier legislation are not. Compare, *e.g.*, *Loving* v. *United States*, 517 U.S. 748, 769-770 (1996) (legislation), and *Red Lion Broad. Co.* v. *FCC*, 395 U.S. 367, 380-381 (1969) (same); with, *e.g.*, *Public Employees Retirement Sys.* v. *Betts*, 492 U.S. 158, 167-168 (1989) (legislative history); *Gwaltney of Smithfield, Ltd.* v. *Chesapeake*

Bay Found., 484 U.S. 49, 63 n.4 (1987) (same); *Consumer Prod. Safety Comm'n* v. *GTE Sylvania*, 447 U.S. 102, 116-118 & n.13 (1980) (same); *United States* v. *Philadelphia Nat'l Bank*, 374 U.S. 321, 348-349 (1963) (same); and *United States* v. *United Mine Workers*, 330 U.S. 258, 281-282 (1947) (same).

In its *Paramount* decision, the Seventh Circuit identified two cases, *South Dakota* v. *Yankton Sioux Tribe*, 118 S. Ct. 789 (1998), and *Rainwater* v. *United States*, 356 U.S. 590 (1958), in which this Court declined to give weight to subsequent legislation in construing earlier enactments. See *Paramount*, 138 F.3d at 711. These cases are readily reconciled with the *Loving* line of authority. In *Yankton Sioux Tribe*, the subsequent legislative materials made contradictory statements about the effect of the prior law at issue, and the Court therefore declined to give those materials significant weight. See 118 S. Ct. at 804 (emphasizing that legislative record "reveals no consistent, or even dominant, approach to the territory in question, and it carries but little force in light of the strong textual and contemporaneous evidence of diminishment") (internal quotation marks omitted). Although the Court did state in that case that "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one," see *id.* at 803 (quoting *Philadelphia Nat'l Bank*, 374 U.S. at 348-349), it did not suggest that subsequent legislation should never be given heed in determining the scope of an earlier law passed by Congress.

Rainwater involved the applicability of the False Claims Act to civil claims against a wholly owned government corporation. It was argued in that case that Congress's amendment of the criminal (but not the civil) provisions of the Act in 1918, to cover "any corporation in which the United States of America is a

stockholder," suggested that the 1863 Congress that enacted the False Claims Act did not intend it to apply to any government corporations. The Court found the 1918 legislation not probative of the scope of the original Act because the amendment was evidently concerned with different kinds of corporations, in which the government might have an ownership interest, and not wholly owned government corporations. See *Rainwater*, 356 U.S. at 593-594. The Court did not suggest that subsequent legislation is *per se* irrelevant to the scope of an earlier statute; rather, it simply found the subsequent legislation in that case not probative.

This case is readily distinguishable from *Rainwater* and *Yankton*. In this case, Congress has unmistakably addressed the precise statutory question at hand in legislation. Petitioners therefore do not dispute that, prospectively at least, the amendments made by Section 4714(a) definitively define the scope of States' cost-sharing obligations. Under these circumstances, the lower court correctly concluded that Congress's clarification of Section 1396a(n) in 1997 deserved great deference in defining the earlier scope of that law.[8]

3. Petitioners argue that Section 4714 effects an unconstitutionally retroactive change in the law gov-

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[8] The Seventh Circuit expressed concern that the *Loving* line of cases would permit an unsuccessful litigant to obtain a "'clarifying' amendment that would reverse the interpretation that the district court had given to [a] statute, *even if that meaning was crystal clear*" before the amendment. *Paramount*, 138 F.3d at 710 (emphasis added). That concern was misplaced, because nothing in the *Loving* line suggests that Congress could in that way alter the meaning of a "crystal clear" statute. Nor is that concern presented here: by the Seventh Circuit's own characterization, the prior rules governing QMB reimbursement were not "crystal clear" but a "hopeless muddle." *Id.* at 711.

erning the States' cost-sharing obligations to providers under the Medicaid Act. That contention, however, necessarily depends on petitioners' characterization of Section 4714(a) as a change in the law rather than a clarification. Because, as we have explained, Section 4714(a) did clarify prior law, petitioners' constitutional arguments are not properly presented. For the same reason, the court of appeals had no occasion to address petitioners' constitutional arguments.

Even if petitioners' constitutional challenges were properly presented, they would lack merit. Petitioners first argue that the application of Section 4714 to their cases would violate the separation of powers principle set forth in *United States* v. *Klein*, 80 U.S. (13 Wall.) 128 (1872), by directing the outcomes of their cases. See 97-1947 Pet. 17-24; 97-1949 Pet. 21-25. This Court has made clear, however, that "[w]hatever the precise scope of *Klein*, * * * its prohibition does not take hold when Congress 'amend[s] applicable law.'" *Plaut* v. *Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995) (quoting *Robertson* v. *Seattle Audubon Soc'y*, 503 U.S. 429, 441 (1992)). Without question, Section 4714(a) amended the law applicable to States' cost-sharing obligations to providers of medical services, and did not simply direct the outcomes of these particular cases. That point is underscored by the fact that Section 4714's amendment to Section 1396a(n) applies prospectively as well as to pending cases. Section 4714 therefore "*did* amend applicable law," *Seattle Audubon Soc'y*, 503 U.S. at 441, and *Klein* has no relevance to this case.

Petitioners' takings and due process challenges to Section 4714 under the Fifth Amendment are also without merit. As explained above, under Medicaid, the States, with the financial assistance of the federal government's matching funds, provide medical assis-

tance to the needy. The Secretary read the pre-1997 Medicaid Act to permit States to limit their cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare would pay for a given service. California had chosen to exercise that option in its state plan. Even if Section 4714 changed the law, the change simply ratified the payment rules already set forth in California law; it did not change the amount that the *federal government* would pay providers. Because Section 4714 did not affect any contractual obligation of the federal government to petitioners, the cases on which they principally rely concerning contractual obligations of the federal government to private parties, *United States* v. *Winstar Corp.*, 518 U.S. 839 (1996), *Perry* v. *United States*, 294 U.S. 330 (1935), and *Lynch* v. *United States*, 292 U.S. 571 (1934), are inapposite.[9]

Thus, the only question is whether Section 4714 effected an unconstitutional taking or violated due process if (by hypothesis) it reduced the amount of cost-sharing that the States legally owed providers for services already rendered. As this Court recently reaffirmed, "a party challenging governmental action as an unconstitutional taking bears a substantial burden." *Eastern Enterprises* v. *Apfel*, 118 S. Ct. 2131, 2146

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[9] Petitioners' assertion that Congress made Section 4714 retroactive to save matching funds is both irrelevant and unsupported. Matching funds are owed to States, not to providers (see 42 U.S.C. 1396b (1994 & Supp. II 1996)); they do not affect the amount of compensation that providers receive for their services from the States. Moreover, Section 4714(a) is permissive. If all the States choose to pay cost-sharing in full, the federal government would still match those payments. Thus, any savings of matching funds would be, at most, "merely incidental" to Congress's regulatory objectives. See *Winstar*, 518 U.S. at 898.

(1998) (plurality opinion); see *id.* at 2156-2157 (Kennedy, J., concurring in the judgment and dissenting in part). Although a plurality of the Court in *Eastern Enterprises* held that the statute under review there effected an unconstitutional taking without just compensation, five members of the Court explicitly disagreed with that conclusion. In any event, the plurality did not disavow any of the Court's earlier takings cases reaffirming that Congress has "considerable leeway" (*id.* at 2149) in enacting social and economic legislation, even if that legislation has a retroactive effect. See *id.* at 2147-2149 (discussing *Connolly* v. *Pension Benefit Guar. Corp.*, 475 U.S. 211 (1986), and *Concrete Pipe & Prods. of Cal.* v. *Construction Laborers Pension Trust for Southern Cal.*, 508 U.S. 602 (1993)).

Application of that settled jurisprudence leads to the conclusion that Section 4714 is constitutional. In determining whether governmental regulation amounts to a taking, this Court considers the economic impact of the regulation, its interference with investment-backed expectations, and the character of the governmental action. See, *e.g.*, *Eastern Enterprises*, 118 S. Ct. at 2146 (plurality opinion); *Connolly*, 475 U.S. at 224-225. All three factors point to a conclusion that Section 4714(a) did not effect a taking. As for the economic impact of the legislation, whereas one plaintiff in *Connolly* had been assessed nearly 25% of that firm's net worth, see 475 U.S. at 222, petitioners have made no effort to show that Section 4714 would have a comparable economic impact on them. On the issue of investment-backed expectations, the law challenged in *Connolly* expanded the employers' obligation to pay benefits, even though those employers had contracts expressly limiting their obligations to pay benefits. See *id.* at 218. In contrast, the California Medicaid plan put petitioners on notice

that payment would be limited to the amount by which California's Medicaid rate exceeded what Medicare pays. See *California Med. Ass'n* v. *Lackner*, 172 Cal. Rptr. 815, 819 (Ct. App. 1981) (California Medicaid rules constitute a promise to pay providers "*at the rates set forth therein*") (emphasis added). Thus, at the time petitioners provided medical services, they had only their hope that their contested reading of the Medicaid Act would ultimately prevail and supersede their contracts with the State. Finally, as for the character of the government regulation at stake, Section 4714, like the statute upheld in *Connolly*, does not permit the government to "physically invade or permanently appropriate any of the [petitioners'] assets for its own use," *Connolly*, 475 U.S. at 225, nor does it have a severely retroactive effect out of proportion to petitioners' own experience, cf. *Eastern Enterprises*, 118 S. Ct. at 2149-2150 (plurality opinion). Petitioners' takings claim is therefore without basis.

Petitioners' due process challenge is similarly without merit. That argument ignores Congress's broad power to enact legislation "adjusting the benefits and burdens of economic life" and to make such legislation retroactive. *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976). Such legislation comes to a court "with a presumption of constitutionality, and * * * the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way." *Ibid.* Retroactive economic legislation passes due process scrutiny as long as "the retroactive application of the legislation is itself justified by a rational legislative purpose." *Pension Benefit Guar. Corp.* v. *R.A. Gray & Co.*, 467 U.S. 717, 730 (1984).

Congress plainly had rational bases for making Section 4714 retroactive. First, Section 4714 conformed federal law to the state-law contract between providers and those States (like California) that had limited their cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare paid. Second, Section 4714 conformed the law to the States' expectations, which were formed by the Secretary's longstanding construction of the Medicaid Act and by the Secretary's approval of state plans adhering to that construction. Finally, it was rational for Congress simply to "correct the unexpected results" of the decisions that rejected the Secretary's construction of Section 1396a(n). *General Motors Corp.* v. *Romein*, 503 U.S. 181, 191 (1992). Petitioners' due process challenge thus lacks merit.[10]

CONCLUSION

The petitions for a writ of certiorari should be denied.

Respectfully submitted.

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SEPTEMBER 1998

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[10] Petitioner Gilmore asserts that retroactive application of Section 4714 violates the Contract Clause. See 97-1949 Pet. 25-28. It is well established, however, that Congress is not subject to the requirements of the Contract Clause. See, *e.g.*, *R.A. Gray*, 467 U.S. at 732-733.

(4) (5)

Supreme Court, U.S.
FILED
SEP 25 1998
OFFICE OF THE CLERK

Nos. 97-1947 and 97-2079

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASSOCIATION DBA BEVERLY HOSPITAL, ET AL.,

Petitioners

v.

S. KIMBERLY BELSHE, Director of the California Department of Health Services, ET AL.,

Respondents

CALIFORNIA AMBULANCE ASS'N and CALIFORNIA MEDICAL ASS'N, ET AL.,

Petitioners

v.

S. KIMBERLY BELSHE, Director of the California Department of Health Services, ET AL.,

Respondents

On Petitions for Writ of Certiorari To The United States Court of Appeals For The Ninth Circuit

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INTRODUCTION

As the petitions establish, review is warranted because these cases present an important issue of statutory interpretation that has split six of the circuits, *i.e.*, the appropriate rate of reimbursement for providers of medical services to qualified Medicare beneficiaries ("QMBs") under the Medicare and Medicaid Acts, an issue of enormous financial consequences because it involves potential recoupment of amounts approaching $400 million in fees previously paid by the Medi-Cal program for medical services already rendered. Equally important, review is also necessary to resolve the jurisprudential question that directly caused the split, *i.e.*, given the courts' Constitutional duty to ascertain the meaning and intent of legislation, what deference is owed to a statute passed by later Congress which purports to clarify the meaning of a statute enacted by an earlier Congress, especially when Congress directs retroactivity only as to litigants.

Petitioners contend that because the two circuits faced with the deference issue became so entangled in deciding how much deference should be given, they failed to recognize the necessity of first ascertaining the intent of the Congress that enacted the original law, a task that lies solely within the purview and jurisdiction of the courts, not Congress. *Pierce v. Underwood*, 487 U.S. 552, 566 (1988). Guided by doctrines those courts interpreted to require controlling deference to the 1997 Congress' clarification of the 1986 Medicare legislation, neither the Ninth nor the Seventh Circuits engaged in any meaningful examination of the 1986 QMB legislation at issue here, including 42 U.S.C. §1396a(n) – the section that the 1997 Congress purported to clarify.

As if to underscore the Ninth and Seventh Circuits' failures to address the meaning and intent of the 1986 legislation, respondents made their discussion of these statutes a cornerstone of their opposition to the petitions in this case. However, in their effort to convince this Court that the "clarifying statute", §4714 of the Balanced Budget Act ("BBA") of 1997, correctly reflects the 1986 Congress' original intent, respondents present an inaccurate and misleading exposition of the Congressional intent be-

hind the QMB legislation and the administrative construction of the earlier "dual eligible" and QMB programs. Since these inaccuracies may directly impact this Court's determination whether further review is appropriate, petitioners address them here.

DISCUSSION

A. The Secretary Materially Misstates the Intent of the 1986 Legislation

The Secretary states, without citing any authority, that the purpose of the QMB legislation was "to relieve the States from the financial obligation that they would have to shoulder under their Medicaid plans if QMBs were not able to participate in the Medicare Part B program." Brief of Federal Respondent ("Brf. F.R."), p. 14. As the four circuits that did address the intent and purpose of the 1986 QMB legislation made clear, Congress' intent was to protect beneficiaries, not the states.

To begin with, in 1986, when Congress enacted the original QMB statutes, including the later-clarified §1396a(n), the states had no obligation under Medicaid to shoulder any financial obligations for QMBs if the latter were unable to participate in the Medicare Part B program because, by definition, QMBs were *not* eligible for Medicaid. Indeed, as the House Energy and Commerce Committee's Report reveals, the "devastating financial burden" faced by millions of the elderly poor was the crux of the problem Congress sought to address:

> that 20 percent of our senior citizens – 5 million people – *are without Medicaid* or private insurance to supplement their Medicare benefits. These beneficiaries, relying on Medicare alone to finance needed health services, are among the sickest and poorest of our senior and disabled citizens. They face substantial out-of-pocket costs for needed care and can incur devastating financial burdens when illness strikes.

H.R. Rep. No. 99-727, 99th Cong., 2d Sess., 102-03 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3692-93 (emphasis added).

To aid and assist this segment of the elderly poor, the House

Committee drafted two sections of a bill that provided two options for healthcare coverage. The first, §4602, identical to its counterpart in the Senate, which later became §9402 of Pub. L. 99-509, allowed states to expand eligibility for the full range of Medicaid benefits for the elderly and disabled with incomes up to the poverty line. The second option, which became §9403 of Pub. L. 99-509 and contained the QMB provisions at issue here, offered states the more limited option of paying only the Medicare Part B premium and the other Part B cost-sharing requirements for Medicare beneficiaries who met a state's threshold requirements and fell below the Federal poverty line. *Id.*, at 105-6, *reprinted in* 1986 U.S.C.A.N.N. at 3695-96..

The legislative history demonstrates quite clearly that the purpose of the buy-in provisions was not, as the Secretary contends, "to relieve the States" from non-existent Medicaid financial obligations to QMBs unable to pay for Part B benefits. To the contrary, Congress was trying to induce states to provide limited Medicare gap-filling benefits for this class of the elderly poor.

The Secretary also erroneously claims that her "construction recognizes that, if the States did not buy QMBs into Medicare, the States would be required to pay for the medical care of at least those QMBs who are eligible for Medicaid, at whatever their Medicaid rates would allow." Brf. F.R., p. 14. This construction cannot be a proper interpretation of the 1986 QMB legislation because if the states elected not to participate in the QMB program, they were not otherwise required to pay for QMBs who were, at that time, by definition not Medicaid eligible. Pub. L. No. 99-509, §9403, 100 Stat. 1874, 2054-55 (codified as amended at §1396a(a)(10)(E)).

Having erroneously postulated that the states might have to incur Medicaid obligations for at least some of the QMBs who could not participate in the Medicare Part B program, the Secretary opines that it is "reasonable to conclude that the States should not have to pay for medical services at a rate that is higher than the rate at which their own Medicaid plans would otherwise have required payment." Brf. F.R., p.14. But the statutory language and the legislative history demonstrates that

Congress intended that for those qualified *Medicare* beneficiaries who would not be eligible under §9403 for full *Medicaid* benefits, *Medicare* cost-sharing would be exactly what the name implies, *i.e.*, a full sharing of *Medicare* costs and *Medicare* benefits for *Medicare* beneficiaries. *See Pennsylvania Medicaid Soc. v. Snider*, 29 F.3rd 886, 899 (3rd Cir. 1994) ("*Snider*"); *see* also H.R. Rep. No. 99-727, at 104, 106, *reprinted in* 1986 U.S.C.C.A.N. 3607, 3694, 3696.

Had either the Ninth or Seventh Circuits engaged in a true analysis of the meaning and intent of the 1986 legislation, as had the four other circuits that addressed this issue, they would have similarly determined that the 1997 BBA amendments, like the Secretary's position here, were at odds with the intent of the 1986 legislation and could not constitute a "clarification" to which any deference is owed. Instead, the Ninth Circuit merely observed that the courts had encountered "extraordinary difficulty in discovering the intent of the original Congress" and on that basis concluded that Congress' 1997 "clarification" of §1396a(n) was worthy of "real deference." *Beverly Community Hospital Ass'n v. Belshe*, 132 F.3d 1259, 1266 (9th Cir. 1997) ("*Beverly*"). However, "[c]omplexity alone is not enough to trigger *Chevron* [deference]." *Snider*, *supra*, 29 F.3d at 902. Petitioners have elsewhere shown that this deference was not warranted. The Seventh Circuit was properly, but not sufficiently, skeptical in evaluating the same purported "clarification":

> The location of the 1997 amendments in a statute labeled the "Balanced Budget Act" and concerned primarily with cutting the federal deficit hardly creates confidence that Congress was, court-like, interpreting the 1986 statute. It is far more realistic to regard the 1997 QMB provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government. Nothing in the provisions themselves suggests a process of interpretation; they merely declare that the states are not required to reimburse QMB providers at the Medicare rate.

Paramount Health Services, Inc. v. Wright, 138 F.3rd 706, 710 (7th Cir. 1998)).

Nowhere in its opinion does the Ninth Circuit explain how it concluded that §4714's provisions are a "statement of what §1396a(n) had meant all along." *Beverly*, 132 F.3d at 1266. Indeed, nowhere does that court engage in an analysis of the meaning and intent of the 1986 QMB legislation so as to justify its assertion.

The Ninth Circuit's avoidance of any independent determination of the intent of the 1986 legislation through the deference it uncritically accorded the 1997 "clarification" only underscores the importance of this case. Supreme Court review is necessary to resolve the apparent conflict in this Court's decisions as to the judicial "deference" owed to subsequent congressional "clarifications" in light of the fundamental principle that the judiciary, not Congress, is entrusted under the Constitution with the *independent* duty to interpret the meaning and intent of federal legislation. *See City of Boerne v. Flores*, ___ U.S. ___, 138 L.Ed. 2d 624 (1997).

B. Post-Enactment Legislative History

Respondents attempt to bolster their erroneous view of the intent of the 1986 Legislation by an equally mistaken and selective review of its post-enactment history.

1. 1988. Respondents first rely on selected language contained in a Health Energy and Commerce Report accompanying the Medicare Catastrophic Coverage Act of 1988, which referred to the Committee's understanding of the "practice" of some states to limit their Medicare cost-sharing payments. H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess., 61 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 884. Respondents ignore, however, that the same House Report elsewhere states in discussions of its version of the bill: "States would be required to pay the Medicare premiums, deductibles and co-insurance for all Medicare enrollees with incomes at or below the federal poverty guideline and assets at or below twice the supplemental security income guidelines." *Id.*, at 36, 1988 U.S.C.C.A.N. 857, 859. Furthermore, nothing in the three other reports accompanying the 1988 legislation, including a House Ways and Means Committee re-

port, a Senate report, and a House Conference report, indicates that either the full House or the Senate agreed with the Energy and Commerce Committee's initial comments. Indeed, the House Ways and Means Committee noted that for QMBs, states would be *required* "to pay the Medicare premium, deductibles and co-insurance [amounts]." H.R. Rep. No. 100-105(I), 100th Cong., 2d Sess., 6 (1988), 253, *reprinted in* 1988 U.S.C.C.A.N. 803, 808. The final Conference agreement accompanying the legislation did not incorporate any discussion similar to that Respondents rely upon, but instead referenced and reaffirmed the language in the Ways and Means Report. H.R. Conf. Rep. No. 100-661, 100th Cong., 2d Sess., 253 (1988), *reprinted in* 1988 U.S.C.C.A.N. 923, 1031.

Most important, the legislation ultimately passed in 1988 did not modify the payment provisions enacted in 1986 relating to QMBs in 42 U.S.C. §§1396d(p) and 1396a(n); it merely deleted two phrases that had previously made the State's Medicaid program's participation in the QMB program optional. Pub. L. No. 100-360, §301(a)(1), 102 Stat. 683, 748. Accordingly, whatever the House Energy and Commerce Committee meant by its inconsistent report language did not materialize in the form of actual legislation in 1988. [1] *See Rehabilitation Ass'n. of Virginia v. Kozlowski*, 42 F.3d 1444, 1458 (4th Cir. 1994), *cert. den.* 516 U.S. 811 (1995) ("*Kozlowski*") ["the only way to change a law is to actually change a law, not to drop contrary language into committee reports addressing totally unrelated provisions"].

Because of all of this, which Respondents fail to disclose in their opposition, coupled with this Court's general warning regarding the troublesome nature of subsequent legislative history,[2] neither the Second Circuit in *New York City Health & Hosp.*

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[1] Because the report language purports to describe the "practice" of some states under the "dual-eligible" program which was repealed in 1988, it certainly has little value in interpreting §1396a(a)10)(E) or §1396d(p)(3) as to the scope of the states' obligations to make payments for Medicare cost-sharing. *Snider*, 29 F.3d at 898.

[2] *See Pierce v. Underwood*, 487 U.S. 552, 566 (1988); *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 116-20 (1980); *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979).

Corp. v. Perales, 954 F.2d 854, 861 (2nd Cir.), *cert. den.* 506 U.S. 973 (1992) ("*Perales*"), nor the Third Circuit in *Snider*, 29 F.3d at 894, nor the Fourth Circuit in *Kozlowski*, 42 F.3d at 1457, were willing to accept the one inconsistent snippet of post-enactment legislative history contained in the 1988 House Energy and Commerce Committee Report as an indication that Congress intended to enact a wrenching change of its original intent in establishing the "dual eligible" and QMB programs as unambiguously set forth in their *contemporaneous* legislative history, which expressly and specifically stated that the states had to provide full payment for Medicare cost-sharing. *Kozlowski*, 42 F.3d at 1457. *See* S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1943, 2020; H.R. Rep. No. 99-727, at 106, *reprinted in* 1986 U.S.C.C.A.N. at 3696.

2. 1989. The Secretary notes that in 1989, Congress amended the QMB provisions by requiring physicians to accept assignment of claims from QMBs. Pub. L. No. 101-239, §6102(a), 103 Stat. 3805. Relying on an alleged State practice of limiting reimbursement of providers of "dual eligibles" to the Medicaid rate, the Secretary claims that the "specific purpose" of this new legislation was to prevent physicians from exceeding the Medicaid ceilings by billing QMBs for such additional amounts. Brf. F.R., p. 14. The Secretary is wrong.

First, the legislation she describes as "amended ... QMB provisions" is neither an amendment nor is it principally related to the QMB program. Section 1848 of the Social Security Act was added through §6102 of the Omnibus Budget Recovery Act of 1989 ("OBRA '89") as comprehensive physician payment reform under Part B of the Medicare program. Section 6102 created a relative value-based fee schedule for payment by Medicare to Medicare "participating" physicians, replacing the prior charge based system, and established a series of limits for charge reimbursement that applies to physicians not accepting assignments under Medicare that significantly circumscribes their ability to pursue payments from Medicare beneficiaries *above* the *Medicare coinsurance and deductible* amounts (commonly referred to as "balance billing"). H.R. Conf. Rep. No. 101-386, 101st Cong., 1st Sess., 738-63, *reprinted in* 1989 U.S.C.C.A.N.

at 3341-65.

As part of the limitation against "balance billing" by "nonparticipating" physicians, Congress prohibited billing on other than a Medicare assignment-related basis, in the case of QMBs and other dual eligibles. 42 U.S.C. §1395w-4(g)(3). Thus, just as with participating physicians, nonparticipating physicians providing services to QMBs are only entitled to payment of Medicare coinsurance and deductibles, in addition to Medicare's payment, and may not balance bill the patients for any difference between their charges and the Medicare fee schedule.

Second, the Conference Report that accompanied this provision states: "Further, assignment is mandated for all claims submitted for beneficiaries for whom *Medicaid is required to pay Medicare cost-sharing charges*." H.R. Conf. Rep. No. 101-386 at 761, *reprinted in* 1989 U.S.C.C.A.N. at 3364. This statement from the Conference Committee does not reflect any understanding of the practice of some state Medicaid programs of eliminating or reducing Medicare cost-sharing for "dual eligibles" that is even remotely similar to the earlier and gratuitous statements of the House Budget Committee in H.R. Rep. No. 101-247, 101st Cong., 1st Sess., 247, *reprinted in* 1989 U.S.C.C.A.N 1906, 2090, at least as that report is characterized by the Secretary. It also makes clear that QMBs are principally Medicare, not Medicaid beneficiaries, given that it is Medicare cost-sharing that must be paid.[3]

Consequently, in her brief, the Secretary has mischaracterized the nature and context of the 1989 legislation, and has ignored the relevant legislative history from the Conference Committee explaining the limited purpose of the 1989 amendments.

C. Lack of Any Longstanding Policy

The Secretary claims that §4714(a) confirms her longstand-

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[3] Additionally, the House Committee commentary, written more than 20 years after the enactment of §1396a(a)(15) (now repealed) dealing with "dual eligibles" did not purport to construe the statute; it only referred to the "practice" of some states and, therefore, carries little weight. *Perales*, 954 F.2d 854, 861; *Snider*, 29 F.3d 886, 900-01; *Kozlowski*, 42 F.3d 1444, 1458.

ing position before the enactment of the 1997 Act that a state could limit or eliminate Medicare cost-sharing by utilizing the state's Medicaid payment "caps." Two courts, however, have found the Secretary did not have a longstanding consistent position, but, in fact, had previously adopted a contrary position to the one assumed for purposes of the litigation, thereby eroding the deference normally to be afforded. *Perales*, 954 F.2d at 862; *Snider*, 29 F.3d at 902. As to Part B benefits, petitioners have demonstrated that the Secretary's present "litigation inspired" position of 9 years (1989-98), dating from the beginning of the QMB litigation, is both shorter than and directly contrary to her previous longer-standing position of 18 years (1971-89). Calif. Ambulance Ass'n, et al., Pet. for Cert., pp. 6-7. In regulations published in 1987 under 42 U.S.C. §1396a(a)(15) of the Act, the Secretary made it clear that the State's option to pay less than full cost-sharing was limited to a nominal amount "to be paid by the Medicaid recipient ... reasonably related to the recipient's income and resources." 42 C.F.R. §431.626(a)(5). These regulations remain in effect today.

With respect to Part A payments in California, one may describe the Secretary's position as firmly rooted in shifting sand. From the beginning of the Medicare and Medicaid programs, until it changed its policy as of May 1, 1994, California paid the full amount of cost-sharing payments for Part A services. In May of 1994, it adopted a new policy to pay *none* of the Medicare cost-sharing for Part A services, even when the State's Medi-Cal rate exceeded the amount paid by Medicare.[4] This is contrasted with the Secretary's currently-stated policy that "a State may limit its cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare pays for a given service." Brf. F.R., p. 12. According to the

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[4] In regard to Part A, the Secretary misstates the facts when she asserts that "[p]etitioners challenged California's policy, reflected in state regulations and in a state plan approved by the Secretary, of limiting cost-sharing payments to the amount (if any) by which the California Medicaid rate exceeds what Medicare pays." Brf. F.R., p. 9. In fact, the policy challenged by petitioners in *Beverly* provided that California would not pay cost-sharing in any circumstances.

State's policy, it will not pay any of the cost-sharing. Nevertheless, the Secretary approved the State's Plan Amendment incorporating this policy in February 1996. Beverly Community Hospital Ass'n, Appellant's Brief, Exh. 1. Subsequently, when §4714 made it clear that a State must make cost-sharing payments up to its Medicaid rate, the Secretary changed her position and informed California that the policy to make zero payments in all cases was not acceptable. *Id.*, Pet. Reh., at 11 n. 11. The Secretary's change in attitude about the extent of the State's obligation shows clearly that she has not had a longstanding, consistent policy of any sort. *See INS v. Cordoza-Fonseca*, 480 U.S. 421, 446 n. 30 (1987) ["An agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is entitled to considerably less deference than a consistently held agency view"].

CONCLUSION

To paraphrase this Court, when the political branches of the Government act against the background of judicial interpretations of federal statutes already issued through the enactment of retroactive "clarifying" legislation, there is a risk that vital principles necessary to maintain separation of powers and the federal balance will be lost. Petitioners respectfully urge that the *writ of certiorari* issue to review the judgment of the Ninth Circuit in this matter.

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